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COMMONWEAL

HEALTH CARE: the pains and gains

THE MYTH OF NO LIMITS
Christopher F. Koller

THE NEED TO PRESERVE HOPE
Madeline Marget

BECOMING A STATISTIC
John Lynch

CANADA: HEALTH CARE THAT WORKS
Jordan Bishop

HOWARD SPIRO reviews C. Everett Koop • THE EDITORS

BOOKS

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DAVID KIRP
on the art of
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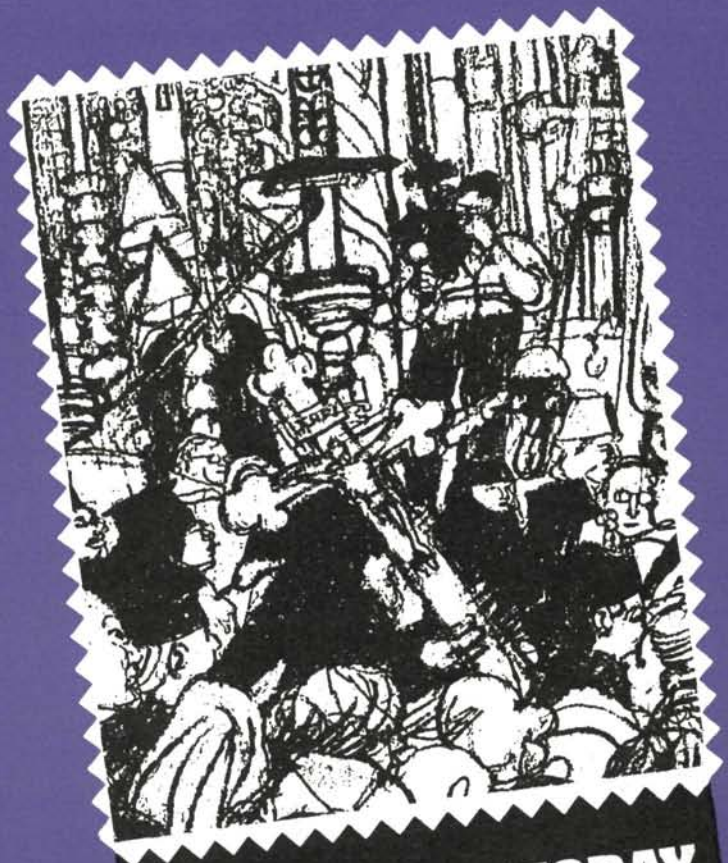

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CORRESPONDENCE

Time for new thinking

Granger, Ind.

To the Editors: Once again J. Bryan Hehir's inability to make a clear and unequivocal decision on the Gulf War is appalling. When the war was in progress he could not decide whether it was just; one year later, in his article "Just Cause? Yes" [February 28] he still could not reach a decision. This indecision is a reflection not only on Hehir but on the inability of the just-war categories from which he writes to provide an adequate framework for Catholics today to reach a moral decision on issues of war and peace. Let *Commonweal* readers hear other voices. Their insights may provide more solid ground for moral decision making.

PATRICIA McNEAL

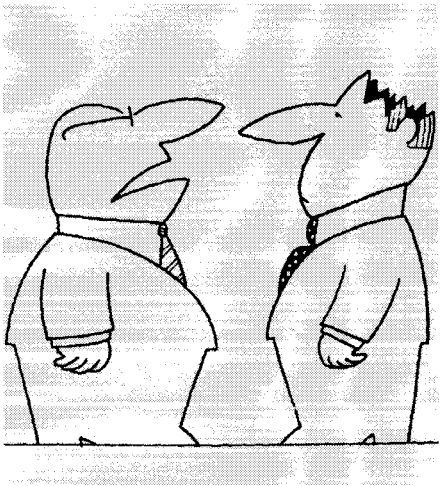
Sarcasm misplaced

Beaver Crossing, Neb.

To the Editors: A subscriber since 1937, a contributor to all of your appeals, today I write to protest these words of ridicule in Robert G. Hoyt's column ["The Catholic Conscience," February 14]: "Let them count their blessings: Their parish is not in the diocese of Lincoln, Nebraska, currently pastored by Bishop Glennon Flavin." Are these people supposed to be grateful that they do not live in a diocese where the bishop stands beside Pope John Paul II on all matters of faith and morals?

On April 4 I shall celebrate my golden jubilee as a priest in this diocese. I give thanks every day that I serve in a diocese that sets the pace for all America in vocations to the priesthood and the religious life. No Catholic schools have been closed under Bishop Flavin. Many new schools have been built and others expanded. I feel we deserve more than ridicule. Unless you repent, you shall lose the only known subscriber in the Diocese of Lincoln.

MONSIGNOR CHARLES J. KEENAN



"Pembroke, have you been trying to make decisions again?"

Choosing to stay

Maywood, Ill.

To the Editors: The emergence of a "church of choice" seems to me far more hopeful than what Paul Baumann's interpretation ["Anna Quindlen's Church," February 28] would have us believe. It's men and women, young and old, who *choose* to belong, remaining Catholic out of conviction rather than custom. Some of their friends leave the church. Others live good and honest lives without belonging to organized religion. There are official and not so official church policies that could drive them away. Yet they choose to stay. They may "wear the church like a hairshirt, but believe no less," writes Morris West.

And I with many others feel confident that, in time and with the help of "the church of the hierarchy," they'll find those forms of expression—some old and some new—which, even "in the whirlwind of modernity," will enable them to celebrate their "loving assent to an extraordinary piece of good news" (Avery Dulles), in word and gesture and work for the poor.

"Sentimentalism"? I doubt it.

REV. JOSEPH BOEL, S.J.

Quindlen & tradition

Rochester, N.Y.

To the Editors: Paul Baumann is on target with his criticism of Anna Quindlen's version of "Catholicism of Choice." The trouble with Quindlen's "democratic" church and the hierarchic church she deplores is that "choice" in both cases easily becomes an illusion. One might label the opposing views: the church of whim and the church of will.

Real choice is the outcome of deliberation within a tradition. Quindlen seems to take off the tradition as easily as her hat and just "makes up her mind." Bad bishops (assuming there are such) abandon tradition for a timeless set of fully consistent principles which always dictate *the* right choice; we always *know* the-right-thing-to-do, we lack the will to do it. But if decision is just whim or will power, there is no deliberation and no choice.

Alastair MacIntyre says, "Traditions, when vital, embody continuities of conflict." Absolutist moralities whether ecclesiastically generated or products of pure reason develop a certainty of moral judgment (for or against abortion) that precludes conflict, dilemma, and tragedy. Morality without dilemma plays well only in heaven and on the op-ed page.

DENNIS O'BRIEN

The writer is president of the University of Rochester.

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Getting well

The litany is familiar—and familiarly depressing. More than 35 million Americans are without health insurance, those who have insurance find themselves paying more for less coverage while catastrophic illness or long-term care for the elderly can threaten any family with bankruptcy. Meanwhile, health-care costs continue to spiral out of control: The $600 billion Americans spend annually represents more than 12 percent of GNP. Most other developed nations offer universal coverage while spending less than 9 percent of GNP.

Although the U.S. leads the world in health-care spending and boasts of the most sophisticated technologies, Americans do not live longer nor are we measurably healthier than citizens of other industrial nations. Worse, our hospital emergency rooms are flooded with needy and uninsured patients while even large corporations, finding a crippling percentage of revenues allocated to insurance premiums, are looking for relief. Health-care reform is in every presidential candidate's platform. Even George Bush has a plan—sort of.

Yet many who have studied the ongoing health-care crisis are skeptical about the chance for reform. The same polls that show Americans eager for national health insurance show them unwilling to pay a dollar more in taxes to fund it. The electorate generally prefers to live with the pain and inequities it knows rather than experiment with those it doesn't. Nor has Congress forgotten the stinging rebuke suffered when its 1988 effort to graft coverage for catastrophic illness onto Medicare was reversed by the shrill lobbying of mostly affluent senior citizens. Even if savings can be wrung out of the current chaotic and inefficient system, extending decent medical care to 35 million people will inevitably increase costs. But that's just the beginning. The nation's health bills are going to increase inexorably as our population ages and as more high-tech interventions against chronic illness become available (Christopher Koller, p. 9).

The obstacles—cultural, professional, and bureaucratic—to health-care reform are daunting, as the several in-depth (and, we hope, balanced) articles in this issue suggest. Yet, for American society to continue to do nothing will only bring greater inequities and turmoil. A consensus for reform may be emerging. For example, enormous savings are thought to be readily available in two areas: curtailing administrative paperwork and restructuring malpractice laws to reduce high malpractice premiums and to reduce the practice of "defensive medicine." Some uniform, perhaps electronic, system of record-keeping and accounting is surely possible. The imposition of standard fees for medical procedures should be part of such a plan.

To reduce defensive medicine, which accounts for an estimated 20 percent of medical costs, C. Everett Koop, the former surgeon general, has proposed a ceiling on awards for pain-and-suffering and binding arbitration to resolve questions of

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accountability. Both are reasonable suggestions.

Most important, however, is to put economic incentives in place that will curtail unwarranted treatment generally. As a good deal of research has shown, it is decisions by health providers themselves, not the logic of any objective measurement of outcomes, that determine the type of medical treatment patients are likely to receive. Treatment for identical conditions varies from city to city, and according to the preferences of the local medical community.

Worse, in our present open-ended, fee-for-service system, doctors have little incentive to manage costs. Indeed, all the financial as well as moral incentives encourage overtreatment. Until recently, insurance companies gave doctors and patients a blank check, and we have used it profligately. But a medical ethos that refuses to recognize limits imposes a cost. It has been paid by the millions of Americans denied any decent medical care at all.

Insurance companies also need to be publicly accountable. Once insurers pooled a broad spectrum of clients, spreading the risk across society as a whole. Competition now encourages insurers to pool only the healthiest clients, limiting risk and thus enabling them to offer lower premiums. Many people in high-risk groups can no longer afford the exorbitant premiums asked. This practice, known as "experience rating," should be prohibited. Private insurance companies should be free to compete—this will help lower costs—but health insurance must be regulated by the government to insure equity and universal coverage.

How can a high and responsible level of care be maintained and excesses reduced in the day-to-day practice of medicine? Managed care or prepaid group practice, best exemplified by health maintenance organizations (HMOs), is one way to bring fair-minded discipline to medical care. Clients pay a set yearly fee for medical services and doctors are on salary. Government could contract exclusively with HMOs and industry could be prodded to do the same if the present tax exemption for health benefits stipulated that managed-care systems be used.

"The treatment will cost $7, 375.79... but hey, who can put a price on good health, right?"

The effort to extend insurance coverage to all Americans should build upon the employer-based and payroll-tax-funded group insurance system we now have. Perhaps some adaptation of the Canadian insurance system (Jordan Bishop, p. 6), in which the federal government mandates and monitors a basic benefit package but administering the program is left up to each province, is the best hope for achieving universal coverage. (Given the size and diversity of needs in the U.S., a system of "regulated pluralism" rather than Canada's "single-payer" insurance model may be the best solution.) Individuals are free to supplement the primary package through added insurance coverage, but basic enrollment is compulsory.

All nationalized systems impose some form of "global budgeting," which caps spending and results in some form of rationing, either in access to the most innovative medical technology (as in Canada) or in access to specific therapies (in Britain dialysis is not available for men over fifty-five). Restricting individual choice is not easy. Witness the effort in Oregon, which wants to extend a minimal level of health care to all the poor by denying some of them certain procedures (kidney transplants for alcoholics, or treatment of premature babies weighing less than 1.1 pounds). Making explicit choices is difficult, but consider: rationing already exists throughout the United States, where the poor are excluded from routine medical care.

Americans loathe the idea of explicit rationing, and for understandable reasons. There is much to be said, after all, for the venerable American tendency to muddle through such irreconcilable conflicts; we are a country of great moral and cultural diversity, and blurring our antagonisms is a time-tested way of preserving the peace and protecting individual dignity. Yet our steadfast adherence to individualist prerogatives—each patient ideally entitled to all possible treatments—may deprive us of the moral resources needed to resolve a problem that requires broad-based sacrifices.

Daniel Callahan has argued that the health-care system will not respond to managerial reforms and that the efficiencies now being trumpeted will prove illusory. Not the failures, but the very success of modern medicine—its palpable promise to "cure" all illness—drives our insatiable desire for ever-expanding medical care. "A denial of the limits of the possible in effecting cures is thus a central part of the ideology of scientific medicine," Callahan writes in *What Kind of Life* (Simon & Schuster). Given the primacy Americans assign to individual freedom of choice, Callahan continues, there is no way to curtail the demand and therefore the cost of modern medicine. If our personal desire is to live longer, and medicine can manifestly accomplish that, who can say no?

Callahan urges us to turn away from such a self-defeating quest in order to guarantee a basic level of health to all while reorienting the practice of medicine to the reasonable rather than the heroic care of the dying. Health should be placed in its proper relation among other social goods. Callahan's stark critique is revelatory. One has only to read Madeline Marget's story ("The Need to Preserve Hope," p. 12) of Dr. Joel Rappeport's heroic

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and miraculous battle to save young Patrick Hough from Wiskott-Aldrich syndrome to see the very paradox Callahan describes. In the unassailable pursuit of health and cure, do we not increasingly risk sacrificing many other human values?

Yet, it has proven difficult, if not impossible, to persuade American voters that the poor deserve, as a matter of justice, a decent roof over their heads or a job that might enable them to pay for that roof. The task of convincing voters that the poor should have medical care at a level roughly equivalent to other Americans seems forbidding indeed. No one knows if we as a nation will be able to turn away from the promises of absolute self-determination that modern medicine so dramatically embodies. Much work needs to be done, and religious communities that have preserved a sense of moral authority in which individual sacrifice is given a meaning in relation to a larger good may be the best place to start. Without that sense of common values, the just allocation of limited resources is impossible.

In the meantime, the first step is to recognize that a health-care system, like the extension of voting rights to black Americans in the 1960s, should be an expression of the enduring American belief that "all men are created equal, and endowed by their Creator with a right to life, liberty, and the pursuit of happiness." American government was constituted to protect that claim to life, and surely life's continuation in the face of illness should not turn on the accidents of wealth and privilege.

AN EDITOR'S NOTEBOOK

CLARENCE T & CAMP J

HARDEN NOT YOUR HEARTS

In the February 28 issue of *Commonweal*, Michael Chapman, inmate No. 98764 at the Louisiana State Prison, Camp J, Angola, Louisiana, reflected on why prisoners become "hardened." He listed a series of factors and concluded: "Add to that having to deal with a cold, callous, uncaring prison system, and a judicial system more interested in the money."

Now, much of the nation has heard about another Camp J inmate, No. 91888. He is thirty-two-year-old Keith J. Hudson, sentenced to twenty years for armed robbery. Last month the Supreme Court, by a vote of 7 to 2, ruled that Hudson's constitutional rights were violated by prison guards at Angola in 1983. They beat him en route to a solitary confinement cell, striking him repeatedly in the head, face, and body, even though he was handcuffed and shackled. There were no amateur video cameras present (although two corroborating witnesses did come forward later). Hudson got "only" a battered face and body, a split lip, loosened teeth, and a broken dental plate. But he took up his pen and, unassisted, filed a complaint. He sought $50,000 in damages and an order "to prohibit cruelty to myself and other inmates housed at Camp J."

In 1987, a judge awarded Hudson $800 in damages, not only for the physical abuse, but for the crude and racist remarks made by the guards. In 1990, however, a three-judge federal court of appeals reversed the decision. The judges wrote that the guards had used unreasonable, excessive, and wanton force, but that their actions had not been unconstitutional.

Hudson appealed to the Supreme Court. In his petition he argued that the appeals court had failed to protect his rights, guaranteed by the Eighth Amendment, against cruel and unusual punishment. The appeals court ruling fell short, he wrote, because of its negligence in not "considering the '*mental injury*' sustained, which is more significant than physical damage." Writing for the Court majority, Justice Sandra Day O'Connor agreed that Hudson's Eighth Amendment rights had been violated: "When prison officials maliciously and sadistically use force to cause harm, contemporary standards of decency always are violated."

Simple enough. Justice had been righted; case closed. Not quite.

In fact, the Court's *Hudson* decision has much more to teach. In his dissenting opinion, signed also by Justice Antonin Scalia, Justice Clarence Thomas wrote that "a use of force that causes only insignificant harm to a prisoner may be immoral, it may be tortious, it may be criminal...but it is not 'cruel and unusual punishment'" under the Constitution.

Last fall during his confirmation hearings, Justice Thomas told the Senate Judiciary Committee that almost every day he looked out the window of his appeals court office to see bus loads of prisoners being driven away. He told the committee that he hoped to bring "something different to the Court," an understanding of the underprivileged.

Thomas's dissent in *Hudson* may indicate the thrust of his judicial doctrine, but it shows little understanding of inmates and less compassion. The Eighth Amendment, Thomas writes, does not generally apply to prisoners because the framers of the Constitution "simply did not conceive of the Eighth Amendment as protecting inmates from harsh treatment." Furthermore, he states, the Court's majority finding is "yet another manifestation of the pervasive view that the Federal Constitution must address all ills in our society....The Eighth Amendment is not, and should not be turned into, a national code of prison regulation."

Since ascending to the Court, Justice Thomas's decisions have been consistent: in every case but one (a death-sentence case in which he was the lone dissenter) he has voted with Justice Scalia. Thomas's votes include the limiting of political asylum for refugees fleeing forced conscription (in the case of a young Guatemalan, fearful that rebels in that country's civil war would murder him if he did not join their ranks); the refusal to stay the deportation of Haitian refugees; limitation on the scope of the Voting Rights Act in an Alabama case in which newly elected black representatives were stripped of some of their powers by white commissioners before they could take their seats; and a weakening of National Labor Relations Board regulations that allowed union organizers to leaflet in parking lots adjacent to stores they are attempting to organize.

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Yet, it is his strongly written dissent in *Hudson* that most clearly articulates Thomas's approach to the law and how it affects vulnerable individuals it is meant to protect. Not only had Hudson not suffered "a serious deprivation," according to Thomas, but the Court had extended him constitutional protection "beyond all reasonable limits." In her majority opinion, Justice O'Connor countered Thomas head on. His dissent, she wrote, ignores the "concepts of dignity, civilized standards, humanity, and decency" that animate the Eighth Amendment.

Back at Angola, where 85 percent of the inmates are black, word has spread of Thomas's opinion. Wilbert Rideau, editor of the prison newspaper, reacted this way: "[Thomas] has forgotten his roots, or may remember them too well and...is trying to distance himself from them," he told a reporter. "There's no sense of obligation, no sensitivity, no nothing." Justice Thomas's direction ought to be a concern for all of us, whether on the "inside" or the "outside." For like some Camp J inmates, he too has a lifetime term. Unfortunately, already it seems to be hardening him.

PATRICK JORDAN

REPORT FROM CANADA

BUSH VS. THE FACTS

HEALTH CARE THAT WORKS

President George Bush, in his attempt to deal with the issue of health care, felt it necessary last month to engage in the common—in the United States—right-wing practice of Canada-bashing. He announced that in Canada there is a six-month wait for bypass surgery and declared Canada's health-care system to be bureaucratic, inefficient, and undesirable.

Such charges are not new, although even conservatives seldom make them in Canada where support for the country's health-care system stands at 86 percent. What characterizes many of the attacks on Canada's health-care system must be attributed either to ignorance or to deliberate misinformation. It is commonly portrayed by its critics as "socialized medicine" and is assumed to be a bureaucracy run wild.

In fact, Canada funds health care through universal insurance, organized on a province-by-province basis, although federal support has ensured uniform minimal standards. Doctors engage in private practice and are paid on a fee-for-service basis, much as in the United States. Patients can choose their doctors and—the insurance being universal—can be admitted to any hospital. Agreements between provinces cover those who are traveling within Canada, although Canadians who are traveling to the U.S. are advised to purchase extra coverage from private-sector insurers, since the coverage provided in Canada is not usually enough to pay bills incurred in the U.S.

The basic funding varies from one province to another. In Ontario and Quebec, premiums are paid through payroll taxes. In Nova Scotia, a 10 percent provincial sales tax is paid into Medical Services Insurance (M.S.I.), the provincial insurance agency. In Alberta and British Columbia, premiums are paid by individuals or families. Premiums for an individual in British Columbia come to $64 per month. Saskatchewan, New Brunswick, and Newfoundland finance the system out of general revenue. In every province the federal government shares the costs of health care, although the present Conservative government has been reducing such assistance. And in every province coverage is universal. Federal cost-sharing is contingent on the universality of access.

The Canadian program—or, better, programs—cover both medical and hospital services. In several provinces, drugs are also included for those over sixty-five. In Nova Scotia, children under sixteen receive dental care. And for the rest, the private sector flourishes, much as in the United States. Canadians get private-sector coverage for dental care, for prescription drugs, for the extra cost of basic services incurred (for example, when visiting the U.S.), for certain mental-health services, and for a private room in a hospital. Unionized workers bargain for benefit packages just as they do in the U.S., except that basic medical and hospital services are provided through provincial programs.

On the whole the system is effective. It is more expensive than Great Britain's national health service, but considerably less expensive than health care in the U.S. (According to the *New York Times*, 1990 per capita health-care spending—in U.S. dollars—was $1,991 in Canada; in the U.S. it was $2,566.) Since there is but one insurer in each province, cost control has proven relatively effective. In contrast, in the U.S. there are over fifteen hundred insurers and administrative costs are considerably higher. Nova Scotia's M.S.I. reports administrative costs of 2 percent. This is probably a case of small is beautiful: the whole population of Nova Scotia is less than 1 million. The 2 percent figure does not include internal hospital administration, or the administrative costs of individual medical practices, although these are simpler for medical practitioners who have only one insurer with whom to deal. Last year, the cost of M.S.I. in Nova Scotia ran to $863 million (Canadian dollars, about $745 million U.S.), of which 61 percent went to hospitals, 21 percent to physicians, 6 percent to pharmacy expenses, 4 percent to capital expenditures, and 2 percent for administration. The remaining 6 percent went to public health and community-based health care. Nova Scotia, a poor and underdeveloped region of Canada, gets good value for its money. It boasts the lowest infant mortality rate in the world.

As everywhere else, costs of health care have escalated in recent years. In February Canada's health ministers met to discuss the problems they face. Their recommendations point in the direction of some serious restructuring of medical services. The number of medical doctors in Canada has increased more than the increase in population, and it appears that costs have increased with the number of physicians. The ministers recommended a 10 percent cut in admissions to medical schools—a recommendation that was sharply contested by some professionals—and that serious attention be paid to the idea of moving away from

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fee-for-service as a basis for paying medical professionals. Other ideas that were discussed were to make greater use of other professionals such as trained midwives. There was also considerable discussion of moving toward a system in which hospitals have a different role. Quebec has already set up a number of community health centers and has implemented a deterrent to discourage the use of hospital emergency services in areas where community centers exist.

Reform will not happen overnight, and some problems are extraneous to the health-care system as such. Some doctors, for example, have been known to send aged poor people—too poor to pay their heating bills—to the hospital when they are faced with colds or other viral infections that could become life-threatening. In such instances, hospitals are called on to make up for the inadequacies of the welfare system, at a cost which is astronomically higher.

Some of these problems are "historical." The Canadian system began in an era (early 1970s) when hospital care was assumed to hold a central place in treatment. Today, critics question whether it should. Some claim that Ontario, for instance, could maintain its present quality of care with half the number of hospital beds, simply by applying appropriate technologies to various situations. In years past, a case of pneumonia meant days or weeks in a hospital. Today, with antibiotics and visiting nurse services, pneumonia can be treated at home.

Canadians do not claim that their system, or systems, are an answer to all problems. The United States currently has a number of circumstances that do not apply in Canada. The cost of malpractice insurance, for example, is almost nominal in Canada. This in turn is related to Canadian court practices and, to some extent, to the fact that Canada has a universal health system. And then the U.S. is much larger. The population of Ontario—Canada's most populous province—is less than that of greater New York City. And however one may appeal to economies of scale to justify bigger and bigger business, the fact remains that there are also diseconomies of scale. These things are no doubt relative, but small is sometimes not only beautiful but more efficient.

And what of Mr. Bush's example of a patient in Canada waiting for up to six months for bypass surgery? This writer had a colleague who was suddenly in need of such surgery a few years ago. He lived in Nova Scotia and underwent the bypass operation in Toronto—sixteen-hundred miles away—four days later. It was successful. This picture, most Canadians would say, is far more typical than delays for urgent treatment. What is much more important to most Canadians is that ordinary, essential, and routine things such as prenatal care, childbirth, and postnatal care are effectively and efficiently provided to everyone who needs them. Canadian physicians are also increasingly looking to preventive medicine rather than responding to crises. But while structural problems remain and there is clearly room for reform, Canadians looking south are immediately struck by the fact that in the United States 35 million people—more than the entire population of Canada—are not covered by medical insurance. It seems clear from here that the whole debate in the U.S. over health care has to be refocused and that President Bush's approach is clearly inadequate.

JORDAN BISHOP

Jordan Bishop, a frequent contributor to Commonweal, *lives in Ottawa.*

OF SEVERAL MINDS John Garvey

NOSTALGIA FOR WHAT?

TAKING AMERICA BACK FROM WHOM?

People speak of having had a happy childhood, and some (they are another kind of human being, not my sort) even speak of having had a happy adolescence. I don't remember my childhood as having been particularly happy or unhappy; I do remember moments of intense joy, and other moments of intense sadness. Intensity, energy, and clarity are the qualities I remember most. The present moment had a vividness I would sometimes like to use now, like a drug, if I could get my hands on it. Perhaps these qualities are there so powerfully in childhood because children have relatively few of the attachments to past or future, real or imagined, that drag you away from the present moment.

Some of the things I remember most vividly are now gone forever. I listened to radio dramas—"The Shadow," "Sky King," "The FBI in Peace and War," "Suspense"—and read magazines like *Colliers* and the *Saturday Evening Post,* which had short stories, some of them pretty good, and good cartoons. The newsstands were full of pulp magazines with titles like *Astounding, Amazing, Fantastic, Worlds of If, Galaxy, Fantastic Universe,* and the more sedately named *Magazine of Fantasy and Science Fiction.* I read them all. When I wanted to read the gory EC horror comics, I went down the street to the house of a friend whose mother, more permissive than mine, let him buy them. (I remember my friend's father for his wrists: he had chains tattoed around them.) On Sundays our town was quiet: only one grocery store, run by a Jewish family, was open. At Christmas time the pictures of little New England towns with snow falling and brightly lit churches seemed right to me; in some ways the world was like that. There was something consoling and pleasant in all of the unexamined assumptions that governed my view of the world.

That seemed like such a good world in so many ways, and it is gone now forever. So are the signs I saw in some local restaurants: "We reserve the right to seat our customers." This meant that black people weren't welcome there. Much of the world I had grown up in was benign and pleasant;

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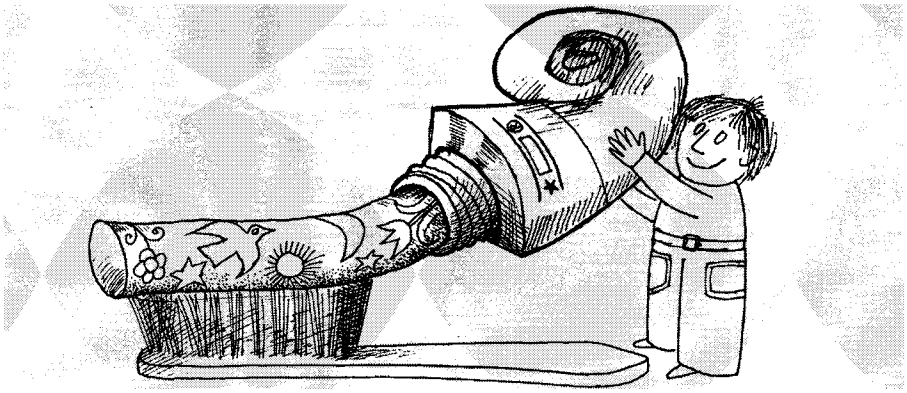

this part certainly wasn't. The assumption of unanimity was true in one way (the black families in town also participated in the sabbath quiet) and not in another—the same black families were cut out of almost anything else the rest of us assumed, placidly, to be the case.

But I say "the rest of us," and mean the people who were the children of that time. A lot of adults found the time complicated and strange, full of unresolved and often tragic conflict, about race and other things. When I grew older and began to read the fiction and criticism that were produced by adults during the time that I remembered as golden, as a cozy world like the world inside the little glass Christmas globe you shook to see the snow fall on a little church or reindeer, I saw that my memory was in fact the memory of a child: accurate, vivid, and intense—but within rather narrow limits, and in an adult those limits are inexcusable.

I think a world in which there is some measure of agreement on moral values, on common life, on a sabbath—a time when, at the very least, we will agree that what we spend most of our time on does not really matter as much as something else, as time spent with family and friends or time spent in silence on a day when commerce stops—is a better world. Pluralism has not answered in any adequate way the question of how we can live as a common society without common values, a society which, if it does not agree on what does matter, at least is able to agree on what does not. That would seem a minimum agreement for any kind of getting on, and we don't have it. The front page of the Metro section of the *New York Times* recently featured the photo of the front door of a New York school in which two children had been murdered by a third, a door bearing a sign which informed students (presuming they could read) that weapons could not be carried inside, that on some days all would be searched, on all days some might be searched, and that, if weapons were found or a search refused, the students might not be allowed to enter. This really is the end of a lot of what most people assume to be civilization.

It is a reaction to this kind of horror that makes some people conservatives. They remember, or at least can imagine (and some mistake the imagination for real memory), something better. They see an obvious degeneration of common life, and they are not at all off the mark. They see liberal thinkers for whom forms of violence, indifference to sexual morality, and the degeneration of common life are, variously, forms of protest against the existing unjust order, rebellion against puritanism, and an assertion of cultural pluralism. They are suspicious of this sort of thinking, and they are right.

But what conservatives do not see is the damage presented precisely by a capitalist, free-market approach to life and to the values they claim to love most. The values of the small community, the local market, are the first to be destroyed by the much more efficient mass-buyer, the Waldenbooks or the Grand Union or the K-Mart. That cherished relationship between the customer and the small merchant is destroyed by an obviously more efficient (and more impersonal) mechanism. And of course as consumers we will always choose the way that saves us money, especially as times get tough. It is precisely the idea of profit as a value to be cherished above all that destroys sabbaths, and makes a common quiet impossible. It is the idea that a profit margin matters more than a relationship with a merchant that makes buying and selling the inhuman, and inhumane, process it is. Given the mechanisms of the market it is hard to see how this could be avoided. It is the deification of those mechanisms, the belief that no one has any right to object to them, or to their effect, that has given us a culture driven by desire. Individual rights matter to us, not the obligations that have been the cement of most social organizations. Democracy offers a better, or at least more accessible, language for rights than for obligations.

And that is a profound danger now, because we have come to the end of something. There was a common culture, a common moral capital, that could be drawn on socially, and it depended on a belief in a more or less homogeneous culture, one which accepted a roughly common set of standards: there are some things one does, and does not, do. That culture might not have existed in fact, but there was a common illusion that it did, and that may matter as much to a social fabric. At the same time, a false nostalgia—the sort of thing Reagan appealed to, and Bush tries to—ignores too much. A false nostalgia rules the American conservative's worldview, and it can get ugly, as in Pat Buchanan's call to "take America back" (from whom?). There is no serious liberal alternative. Because they have talked a little about the economy, Democratic political candidates have been praised for being "more serious" this year than those in the last couple of presidential races; but this is a little like saying that Laurel and Hardy are more serious than the Three Stooges—it may have a shade of truth, but so what? There has yet to be a real *idea*, new or otherwise, floated by any candidate. We are offered variations on old themes by members of both parties, and voters, sensing that no real help is forthcoming from anyone, are unhappy with all of their choices. It may encourage Democrats to see Bush unpopular; but the polls also show that the voters don't see a real alternative in *any* of the candidates. Several people have floated the idea that the ballot should contain a "none of the above" choice; if it got the greatest number of votes, no candidate on the ballot could run in the next election. It might be a beginning. □

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THE MYTH OF NO LIMITS

CHRISTOPHER F. KOLLER

ALL HEALTH CARE IS TEMPORARY

The "request for coverage" has reached the senior management of the insurance company. A thirty-eight-year-old patient diagnosed with metastatic breast cancer and her physician are requesting the carrier pay for an Autologous Bone Marrow Rescue (AUBMR) for the woman—her "last best hope for survival," the request maintains. The patient will receive the procedure only if the insurance company agrees to it.

Medical care in the U.S. now involves two decisions: "appropriateness," what is best for the patient, and "coverage," what is agreed to in the patient's insurance policy contract. Considerations range from the principled, clinical efficacy and patient condition, to the pragmatic, prior payment decisions, legal precedent, risks of lawsuits, and adverse publicity. This is how we decide who receives medical care in the U.S.: a case-based ad hoc allocation process biased toward technology-intensive procedures and identifiable, insured, very sick patients. Unfortunately, this process often fails the needs of both patients and society.

Breast cancer will strike one in ten women. Early detection techniques, such as mammography and breast self-examination, and treatment advances involving surgery, radiation, and chemotherapy, have made the prognosis for the disease quite good. Ninety percent or more of patients with breast cancer detected and treated in its early stages can expect to experience no recurrence of the disease. For the remaining 10 percent and those who do not detect the disease early, however, breast cancer is likely to be fatal. Long-term (five-year) survival rates dip to 50 percent if detection occurs after the cancer has spread to adjacent lymph nodes, and to 10 percent if other organs are affected.

Autologous Bone Marrow Rescue (AUBMR) represents one of medical science's newest and most powerful weapons to improve survival rates for this and other cancers. It is also perhaps the best example of a host of high technology, resource-intensive procedures available in the U.S. which raise questions about their appropriate use and application in a society with limited resources to spend on medical care.

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AUBMR is logically simple and technically dazzling. Since the effectiveness of chemotherapy is limited by its destructive effects on the recipient's white blood cells, researchers have devised methods of "harvesting" the patient's bone marrow prior to chemotherapy, blitzing the cancer (and the patient) with lethal doses of anticancer drugs, and then reinfusing the bone marrow to "rescue" the patient. It is a radical intervention in the body, a manipulation of a life pushed to death by the disease and the cure. Compared to it, a heart transplant appears merely to be complicated plumbing.

AUBMR is expensive. Prices quoted by institutions for the treatment, hospitalization, and physicians' fees range from $85,000 to $150,000. It is dangerous; anywhere from 5 to 20 percent of those undergoing the procedure succumb to the toxicity of the drugs or resulting infections. It also apparently works for carefully selected patients. Very early clinical trials report disease-free rates at five years of 80 percent for breast cancer patients with lymphatic involvement and 30 percent for patients with metastases to other organs (compared to 50 and 10 percent for con-

"Affordable *health care? What are you, some kind of socialist?*"

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ventional treatment). Applications of the technology for virtually every other type of cancer are being investigated in North America and Western Europe.

Among the arsenal of high technology medical procedure, AUBMR strikes particular fear into insurance companies' hearts for two reasons. Incidence rates for breast cancer are sufficiently high that widespread application and acceptance could mean significant additional expenses. Less calculable but more costly is the potential for bad press generated by a widely publicized denial-of-coverage decision and any subsequent legal appeal.

The role of health-care-rationing agent is a new one for private insurance companies. In the past, health insurance paid for "generally accepted" medical procedures, and research institutions and the federal government picked up the tab for "experimental" or "investigational" procedures. These new technologies were generally limited to a few major research institutions; patients were selected on the basis of access to the centers and their researchers. As efficacy was clinically demonstrated, for example, in the case of heart transplants, the procedure entered the medical mainstream as "accepted" or "standard" practice.

This traditional differentiation between experimental and accepted procedures—more of a spectrum than a dichotomy—is collapsing under the weight of patient demand for treatment (consider the case of AIDS treatments), public sentiment in highly publicized cases, court rulings that have generally overturned denials of coverage, and the profusion of research centers and new medical technologies competing for a shrinking pool of federal research funds.

A free-market attitude toward health-care research and development has evolved in the U.S. Institutions and their captains, anxious to generate streams of funding and prestige, develop research trials for "hot" medical technologies. The pharmaceutical and medical-devices industries look for new "markets" of sick patients for new products, creating demand by courting patients and physicians. Federal regulation of new technologies consists of reviews of patient safety only. As a result of these pressures, availability of the technology proliferates faster than experience or consensus on its appropriate use, and more patients and their physicians are demanding access to a broader range of complex, resource-intensive procedures for which somebody—no longer solely the government—must decide criteria for selection and funding. While the mantle of "victim" rests uneasily on the muscular shoulders of the insurance industry, the case of AUBMR indicates how in the U.S. fragments of society that do not represent the whole are being forced to answer fundamental questions of resource allocation which affect all.

Medical care competes with many other goods—housing, food, clothing, defense—for a limited pool of resources: money, people, time. A free-market-based resource allocation system has proven reasonably effective at delivering shirts and bread for those who need it, while still producing diamonds and caviar for those who can afford them. If AUBMR and other new and expensive medical technologies are not luxuries, health care's Rolls Royces and Ferraris, their allocation should not rest with laissez-faire principles of benign neglect or unrepresentative institutions.

Who should receive AUBMR for breast cancer? More importantly, who decides? A war story for beleaguered insurance companies involves a health maintenance organization which agreed to cover AUBMR for a patient with breast cancer, provided she went to one of five premier research institutions with which the company had existing relations. All five medical centers turned her down as an inappropriate candidate, but the patient then found a center just starting its program which was willing to take her on. Concurrence by five separate authorities is as close to consensus as medicine can manufacture: Was the woman still entitled to the procedure?

As a society, we desperately want to say "anyone who needs a medical procedure, gets it." This response reinforces cultural traditions of human rights, personal autonomy, and benign neglect on questions of resource allocation. Clearly, however, not everyone who wants AUBMR for breast cancer can receive it in the U.S. today. The 35 million people who are uninsured have limited access to the procedure, as do the millions more on state and federal insurance programs, and the large and growing numbers of "underinsured." Moreover, no system of health-care delivery, the besieged U.S. model or its ballyhooed Canadian cousin, can deliver everything to everybody who wants it. Language of "rights" or "autonomy" fails in a realm of limited resources; some institution has to decide at what point one AUBMR is not worth the three thousand prenatal visits which could be funded instead, or a similar number of screening mammographies which could detect perhaps five additional cases of breast cancer before serious complications.

Disenchantment with the U.S. health-care system can be broadly categorized as involving its cost, its inequitable distribution, and its increasing depersonalization of care (in the form of greater specialization, administrative processes, and fragmentation of services). The Democrats, emboldened by last November's U.S. Senate race in Pennsylvania, have seized national health-care reform as the mouthpiece of their lost populist voice. However, they have yet to adequately recognize that any legitimate attempt to address these issues must come to grips with the allocation of limited resources among seemingly limitless treatment and diagnostic technologies.

How would such allocation be made? Often, it is done through incremental policy making, affecting the supply of a certain technology. A national policy that controls the number of facilities approved for experimentation with a new treatment or procedure would both limit its availability and create fewer but larger experimental trials. Limiting the number of centers performing a procedure creates a rationing by queuing, in theory the long wait weeding out the less needy. Tight certificate-of-need requirements for the acquisition of new equipment by medical centers also limit their dispersion.

There are more comprehensive steps that can be taken to ration health care. Health-care economists point out that consumption of complex medical technologies is a function of neither resource supply nor patient demand but of physician availability: limit the number of specialists certified in a given field and presumably

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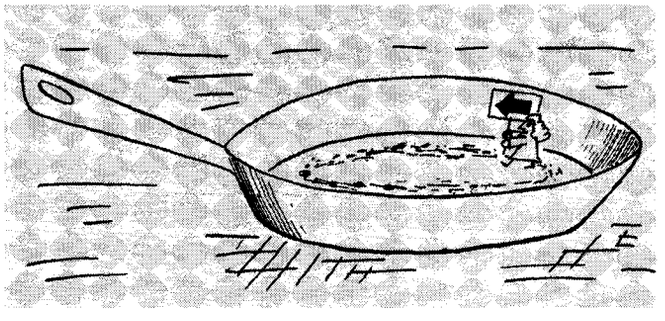
unnecessary consumption would decrease. New Medicare reimbursement guidelines scheduled to take effect this year address this in a back-handed way. Some of the incentive for physicians to specialize is eliminated by reducing compensation for technical procedures (for example, traditional Medicare gravy trains such as the treatment of cataracts and prostatectomies) and increasing reimbursement for "cognitive" procedures such as primary-care office visits. Finally "global budgeting" as practiced in Canada attempts to set prospective limits on federal and provincial spending for health care and then negotiates accepted procedures and reimbursement rates to meet those limits.

The ultimate, and perhaps unavoidable, form of rationing in a health-care system is an explicit prioritization of technologies and procedures for reimbursement, one that tries to compare AUBMR to prenatal visits and screening mammographies. The most publicized attempt to do this has been in Oregon, where an elaborate methodology has tried to determine cost-benefit figures for the treatment of hundreds of clinical conditions and then integrate them with patient preferences gleaned from numerous town meetings. The results have been controversial. Child and family advocacy groups have criticized the approach as immoral since it supposedly limited care available to Medicaid recipients, and in one highly publicized case a child died from liver failure in the midst of fund-raising efforts to pay for a transplant denied by Medicaid since it was determined to be a low-funding priority.

Rationing of care, or more politely the allocation of resources, in any explicit way is a pill the U.S. patient may still not be ready to swallow, calls for "national health care" notwithstanding. Perhaps we as a society tolerate the U.S. system and its way of resolving the dilemmas of allocation because it protects us from the responsibility that comes with autonomy, making difficult decisions about others and ourselves. We avoid explicitly saying no to the woman who wants AUBMR or sorting out conditions for a "yes" decision (yes, if lymphatic involvement only, and no if further metastases?) by implicitly saying no to thousands of pregnant mothers who receive their only care in the hospital emergency room. We will struggle to save the life of a low-birth-weight baby but neglect the culture of hopelessness that caused the premature birth.

Perhaps we as a society tolerate the U.S. system because it reinforces the important cultural myth of limitlessness, in which each of us is free to choose whatever we need from an ever expanding array of options to preserve our immortality. Each individual case we encounter ("the identifiable victim") presents a challenge to this myth and we will struggle to defend it. We generate thousands of dollars and newspaper column inches for a single child undergoing multiple organ transplants to preserve her hopes and our own. To ration health-care technology is to limit our own individual choices and hopes by submitting to an imperfect government-imposed system.



There is another component to health-care technology which makes its distribution problematic: it provides hope, however slim, for a prolonged life. And technology has delivered on that promise—yesterday's death-dealing smallpox is today's vaccine—resulting in unimaginable reductions in human suffering and misery. But, as Daniel Callahan has pointed out, most of health care's research innovations have shifted from the broad-based and epidemiological, such as vaccines, to individual patient interventions, such as AUBMR for breast cancer, which produce much smaller incremental gains. There is a final frontier to physical life beyond which technology cannot push. We are limited not only in our choices, but in our life. Technology notwithstanding, "we know not the hour" and at some point technology's primary value ceases to be curative and becomes instead illusory, offering hope against hope. It is a false hope, a false comfort for real fears, alienating one from an integrated view of human life which includes a place for aging and physical decline. The "untimely" death—whether by cancer, failed organs, or an accident—only heightens technology's capacity to delude and alienate patients and their families. Technology is no solace for tragedy.

All health care is temporary. We will die—and this gives us pause. Anything to stay that fear, such as medical technology, offers hope. In the U.S., we leverage that hope by distributing it in a fragmented, inequitable way. We bear a great cost for this system of allocating resource-intensive care. We shortchange the voiceless among us, the growing numbers who can't afford the admission fee of comprehensive medical care and wait outside for handouts. We shortchange individuals who are deluded about the inevitability of decline and death.

We cannot expect more from this woman with breast cancer, a supererogatory sacrifice of any hope of survival for the sake of social good and nameless victims. She is driven as much by fear, uncertainty, and the hope of seeing her children grow as by a careful calculation of the risks and benefits of various treatment options. We can expect more from ourselves: institutions which do not hide the fear of the body's diminishment and death but support principles of dignity and comfort, and which face up to the difficult task of setting priorities and distributing limited resources.

Institutions represent our collective choices. Those which deliver and distribute health care represent how we care for our sick and vulnerable, our selves. They should be rooted in the experiences of frailty and limitation, as well as strength and pride. In our efforts to preserve individual hopes, we have failed to provide a remotely similar range of aspirations; we encourage one another to cheapen what it means to be alive to mere physical survival. □

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THE NEED TO PRESERVE HOPE

THE PAINS & GAINS OF MEDICAL PROGRESS

MADELINE MARGET

When we look at the anguish of a patient and his or her family and the expense of radical efforts to cure a serious, even fatal illness, it is easy enough to understand why we would want to place limits on heroic or experimental procedures. But we also need to think about the cost and grief of not making that effort, of not trying to save a life, and then, when such efforts prove successful, about their great value to other people. I have spent several years studying and pondering this issue, first, when my sister, Roberta, was diagnosed with a rare and deadly form of leukemia and, then, in writing a book about the work of Joel Rappeport, the hematologist who treated her (*Life's Blood*, Simon & Schuster, $23, 301 pp.).

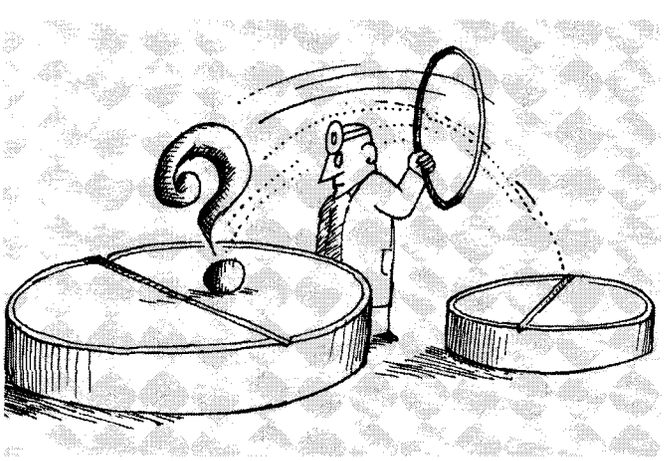
In the course of my research, I met and interviewed other of his patients, including Patrick Hough, Patrick's mother, Pamela, and Patrick's sister Beverly. They shared the story of the long, complex treatment Patrick underwent for Wiskott-Aldrich syndrome. Patrick's older brother Christopher died of Wiskott-Aldrich at the age of four. Wiskott-Aldrich syndrome is a genetic disease that is passed from mother to son, and that, until bone marrow transplants were used to treat it, invariably killed its victims in childhood. Patrick Hough, now in his late teens, was one of the first to undergo a transplant for Wiskott-Aldrich syndrome. He underwent two bone marrow transplants, the first when he was three and a half, and the second when he was five.

Bone marrow transplants have been available since the 1960s. At first entirely experimental, they are now therapy for a number of diseases, in fact, the treatment of choice for some. Over the decades, they have become safer, and the hospital stays for recipients shorter. Still, bone marrow transplants are risky and involve both high financial costs and prolonged periods of sickness, fear, and isolation. The alternative, however, is nearly always death. Bone marrow transplants are usually undertaken in an effort to save young lives, and they often succeed. The procedure has led to a greater understanding of not only normal physiology, but of illness and cure in general. In many ways, bone marrow transplantation is archetypical modern medicine.

MADELINE MARGET, *a frequent* Commonweal *contributor, lives in Newtonville, Massachusetts.**This article is adapted from her book,* Life's Blood. *Copyright © 1992 by Madeline Marget. Reprinted by permission of Simon & Schuster, Inc.*

Bone marrow is the body's blood producer. When bone marrow fails to produce red cells to carry oxygen, platelets to clot, and white cells to fight infection and provide immunity, the patient dies. A bone marrow transplant either replaces diseased marrow (as in leukemia) or supplies a lack of marrow (as in aplastic anemia). In an allogeneic bone marrow transplant—one in which someone other than oneself or an identical twin is the donor—the patient's bone marrow is destroyed with chemotherapeutic drugs and/or radiation, and is then replaced with healthy marrow. This is supplied by the donor; while he or she is anesthetized marrow is drawn from the pelvis through hundreds of aspirations. Afterward, the donor, usually a sibling, is sore and tired but incurs only very slight risk. His or her bone marrow, unlike solid organs, regenerates within weeks.

For the recipient, however, the situation is extremely dangerous. Until the new bone marrow takes hold and begins to grow, the slightest infection could prove fatal. The drugs used to destroy the original disease and to suppress the patient's immune system (so that the new marrow will not be rejected) endanger every organ in the body, and can have horrendous consequences, including death. Even when the bone marrow transplant goes smoothly, the patient has a long hospitalization, experiences intense sickness and weakness, and, once home, faces a long period of recuperation, during which everything has to be kept scrupulously clean, and physical—and even social—contact with other people is largely denied. When a bone marrow transplant is decided on, it is nearly always because there is no other realistic hope for the patient.



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Joel Rappeport, who cared for Patrick during his transplants, is a cranky, chainsmoking, disheveled, always exhausted-looking, and very dedicated doctor. He is in his early fifties, and has been performing bone marrow transplants all of his professional life, first in Boston (where Hough was treated) and now in New Haven. Wherever he is, and whatever the specifics of a patient's illness, Rappeport is obsessed with the details—drug doses, urine output, molecular change—of disease and cure. He is also intent upon learning as much as possible from each procedure, so as to increase the chances of cure for future patients and in order to help eradicate the terrible diseases he is contending against.

In 1976, when doctors first tried a bone marrow transplant for three-and-a-half-year-old Patrick Hough, there had never been a fully successful one for Wiskott-Aldrich syndrome. But analysis of Patrick's continuing illness and treatment pointed to a critical breakthrough and ultimately a cure. "It wasn't a planned attack," Rappeport says. "It was looking carefully at what happened, coming to a conclusion, and trying to solve the problem."

Children with Wiskott-Aldrich syndrome have insufficient and abnormal platelets and T cells (a type of white cell) and are therefore subject to constant and extreme bleeding and infection. Because only boys are afflicted, Beverly, second in the family, was never in danger. Scott, the oldest, was also spared. But Christopher, the third child, was not. Pamela Hough was pregnant with Patrick when Christopher was diagnosed with the condition. The doctors hadn't known what was wrong with Christopher at first, and when they found out, they didn't explain it clearly to the Houghs. Christopher was bleeding internally, his eyes were crossing, and he had terrible eczema.

Patrick, on the other hand, was diagnosed in infancy. He almost died of pneumonia when he was only a few weeks old. Because children with Wiskott-Aldrich syndrome have abnormal lymphocytes, their bodies can't fight infections effectively. But Patrick survived the episode and the others that followed. And so, for several years, Pam Hough had two acutely ill children to care for. The eczema was a torment. Patrick, she says, "would open his mouth and his skin would split and bleed. And there were big clumps on his head. I used to put out two bathtubs, and give them oatmeal baths. And then rub them down with tar cream. And then put little nightcaps on them and cover their hands up, because they would scratch so hard they would bleed. And the skin would get infected and have kind of a smell, an odor to it. It was really hard."

For both little boys, there was hospitalization after hospitalization. Christopher was in the hospital for months with chicken pox. In the hospital, "there were tests," said Pam. "You know, research. And they would give them shots other times. I don't know why." Eventually, Christopher needed an incision in his neck for an IV; his veins had collapsed. "It was just too painful. So I said, 'No, I don't want it. That's it.'" The Houghs took him home, and he died a few months later. There was never any hope for him, because the only possible cure was a bone marrow transplant, and Christopher did not have a compatible donor.

Patrick did: his sister Beverly, who is now a young woman in her early twenties. She was around seven when Christopher lay dying, and remembers it well. "I remember celebrating his birthdays in the hospital. We'd all get dressed up and bring his cake and everything and have his cake in the hospital. It was just an awful time. I remember my parents weren't around. We stayed at the O'Briens' house; they live two houses down. And God, I remember the way Christopher always looked. His face was all broken out, and his eyes and his mouth. And he had skinny, skinny legs and arms. And a big belly. He was always sick. He and Paddy were always sick. It's just awful, how Scott and I are healthy, and they are sick. And I think that's kind of what's most disturbing about it. It just didn't seem right. They were so little. We were little, too. But it just never seemed right; it was odd."

Patrick Hough's first transplant took place in May 1976. At first it seemed to take. "His [blood] counts were rising," Rappeport says. Then Patrick developed an infection, and "in late June, his [hemato] crit dropped," a side-effect of Bactrim, the antibiotic Patrick was taking. The drug was discontinued. But that wasn't the source of the problem. Patrick continued to need platelets. The ones his body produced were not from Beverly's marrow, but the small, dysfunctional ones characteristic of Wiskott-Aldrich syndrome. There were other signs that the graft hadn't taken. The cells were type O, Patrick's original blood type, rather than A, Beverly's, and chromosomal analysis showed a high percentage of the granulocytes—another type of blood cell—to be male.

Patrick had not been cured. He was given platelet transfusions periodically while the doctors decided what to do. "We evaluated him extensively," Rappeport says. "His red cells were his own. Myeloid cells his own. B cells were his own." In naming these cells Rappeport was not only identifying them, but indicating his thinking: blood's components develop from several cell lines; tracing a mature cell back to its origins can reveal the problem.

There was a clue, however. Rappeport: "T cells—which he had not had before—were donor, but over a period of months they began to fall in number. And with that observation we realized [Patrick] had engrafted only what wasn't there, and that not permanently." Beverly's healthy marrow had not firmly engrafted.

In Wiskott-Aldrich syndrome illness comes from an insufficiency of working cells rather than from the aggressiveness of malignant ones. So it was reasonable for Rappeport and his colleagues to assume that they did not have to eradicate Patrick's marrow, but simply get healthy marrow into him. Nevertheless, the fact that absent T cells and defective platelets—cells that descend from different lines—caused Wiskott-Aldrich pointed to the need to eliminate the abnormal pluripotent stem cell, the root of all blood production, and as Rappeport explains, to create "space, not physical space, but some other kind of hematopoietic space," in which the transplanted marrow could thrive.

Rappeport reasoned that it was the preparation that had been faulty in Patrick's first transplant. (At the time, Rappeport had used only immunosuppressive drugs.) He pressed for a second transplant, to be done this time with more intensive preparation, so as to eradicate the stem cell. Because laboratory tests showed that the first transplant had sensitized Patrick to Beverly's marrow,

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graft rejection was likely, and so additional immunosuppressants were given for the second transplant. Rappeport's colleagues, especially his superiors, were reluctant, to say the least, to go along with a second attempt. "They thought Patrick wouldn't survive it," says Rappeport, "and called us Nazis." But to Rappeport it was clear that Patrick would die without a second transplant. Rappeport said so, and his superiors and the Houghs finally agreed to his proposal.

With her grief over Christopher's death still fresh, Pam Hough would stay at the hospital each day until Patrick took his bowel prep, the disgusting-tasting gastrointestinal antibiotic Rappeport's bone marrow transplant patients take several times a day. She remembers, "Patrick would cry, 'My tummy! My tummy!' and he'd throw it up. They would make him do it three times, and after the third time they wouldn't make him do it again. But we'd try to help him get through his bowel prep. Then we'd leave for the night. He had a color TV and a telephone, and all his sterilized toys and food."

There were nurses who didn't look after him properly, who let him lie in his own vomit and diarrhea, so that Pam, coming in to see him, would scrub and gown and glove in the requisite way before going into his sterile room—it took her ten minutes—and then go in and clean her child, flinging the filthy sheets out of the room.

Beverly, who served as Patrick's donor, has not yet been tested to see if she is a carrier of Wiskott-Aldrich, although it is now possible for her to find out. "We can diagnose carriers with confidence," says Fred Rosen, an immunologist who worked with Rappeport. That is, with reasonable reliability but not certainty. Should Beverly turn out to be a carrier, there is also a prenatal test for the disease, making abortion an option. "We can tell for sure by twenty weeks of gestation," Rosen says.

Often in genetic disease, however, no family history serves as a warning. Therefore, abortion isn't always a solution even for people who are willing to consider it. Wiskott-Aldrich syndrome is an extremely rare disease—there are only a handful of cases every year in the world—but common and uncommon genetic disease will always be with us, a fact guaranteed by the process of mutation, which is an essential factor in evolution. What befell the Houghs can happen, in the form of one disease or another, to anyone.

Beverly says that she would not have a child if there were even the slightest chance that he could have Wiskott-Aldrich syndrome. "I just couldn't go through that again," Beverly says. She says of her mother, simply and with assurance, "She's a good person. She was a wreck, physically and mentally, because Christopher died, and Paddy was going through the same thing. But she wouldn't show that to us. I think my mother's very strong. If I were her, I think I would have fallen apart. I couldn't have done that and still lived."

Beverly saved Patrick's life. Now over fifteen years later, she is still full of concern for him, alert to any slights he receives. "His legs are really scarred and everything from the shunts. And

(Continued on page 19)

VIA CRUCIS

JERUSALEM TODAY

Text: Irene McMahon
Drawings: Franklin McMahon

At dawn on Good Friday, the cocks crow and there is a low murmur of prayers as Christians move slowly through the streets of the ancient walled city of Jerusalem. Their prayers express a human longing to relive the Passion of Christ.

More than 1900 years after the death of Christ, devout pilgrims, and curious tourists, from Chicago and London, Frankfurt and Addis Ababa, from Tokyo and Sydney, set out on the path of Christ's dolorous journey to his death on Golgotha, a transhistorical journey that has changed the character of man.

Each person brings his own experience to this place, each chooses his own space: for Jews it is the Western Wall, for Moslems the Dome of the Rock, and for Christians it is the Via Dolorosa, a labyrinthine passage through the old city.

Passions of conquest have destroyed Jerusalem so many times since the first Good Friday that it is now virtually impossible to trace the exact route Christ carried his cross. It is faith that dominates here; not archaeology.

Streets now follow the plan laid out by the Roman Emperor Hadrian in the second century over ruins of the city in which Christ suffered. Sites of today's Stations of the Cross were established in the fourth century when St. Helena discovered the True Cross, and it was her son, Emperor Constantine I, who dedicated the first Church of the Holy Sepulcher.

Crucifixion was a Persian torture used by the Romans who executed slaves, criminals, and the political opposition. Jews were crucified by the thousands. It was not an abstraction when Christ told his apostles to "take up your cross." They had seen the agonies of their crucified brethren lining the roadsides of Galilee.

To meditate on Christ's crucifixion, the crux of Christianity, gives meaning to Everyman's cross; a rekindling of faith and compassion that is catholic in the universal sense. Along the way ancient whispers of the past evoke profound mysteries.

During Holy Week, 1987, Irene and Franklin McMahon traveled to the Holy Land to follow pilgrims on the Way of the Cross. This is what they witnessed in text and drawings. The drawings stand as full-color ceramic tile stations at St. Patrick's Church in Lake Forest, Illinois.

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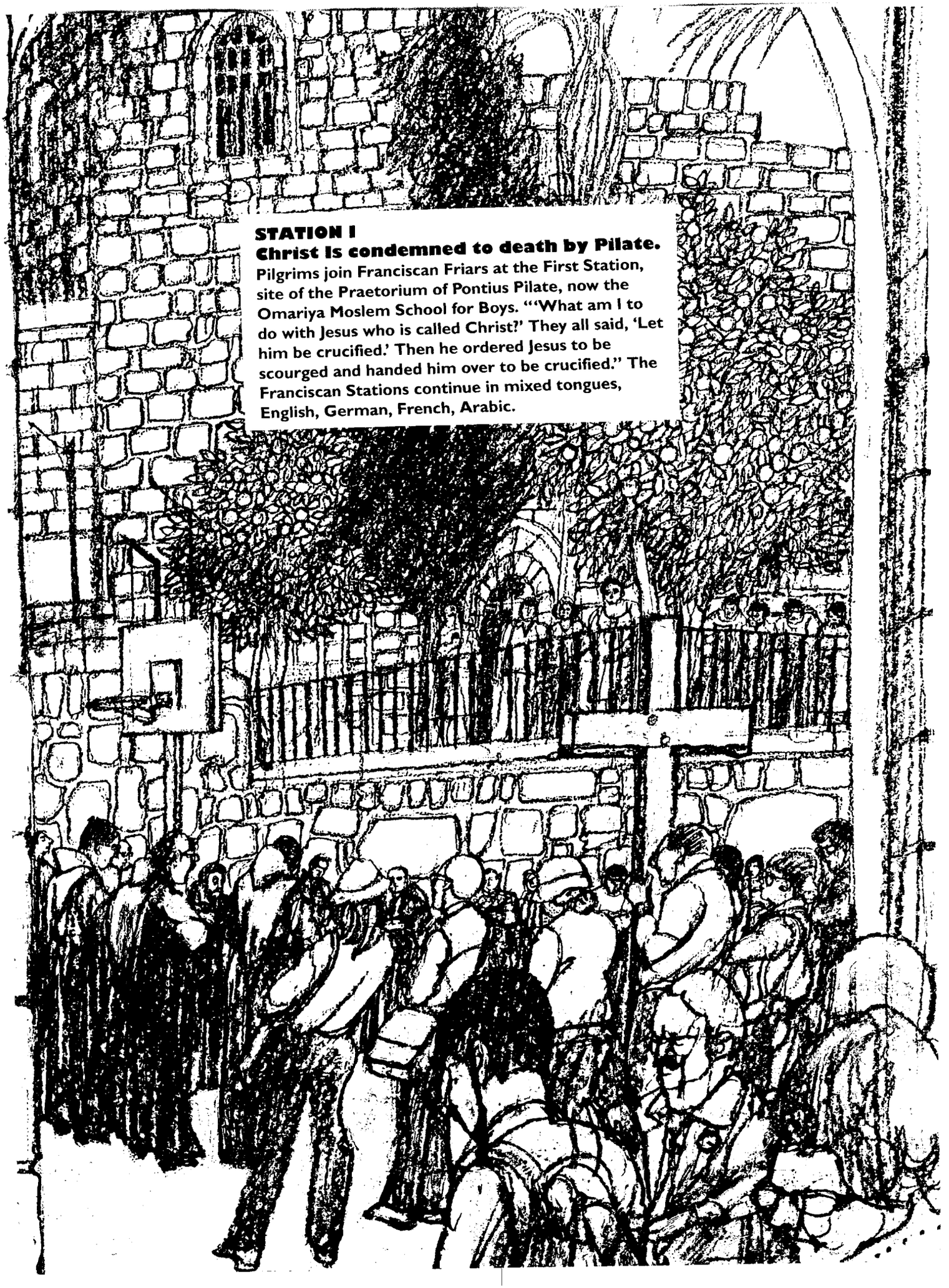

STATION I
Christ Is condemned to death by Pilate.
Pilgrims join Franciscan Friars at the First Station, site of the Praetorium of Pontius Pilate, now the Omariya Moslem School for Boys. "'What am I to do with Jesus who is called Christ?' They all said, 'Let him be crucified.' Then he ordered Jesus to be scourged and handed him over to be crucified." The Franciscan Stations continue in mixed tongues, English, German, French, Arabic.

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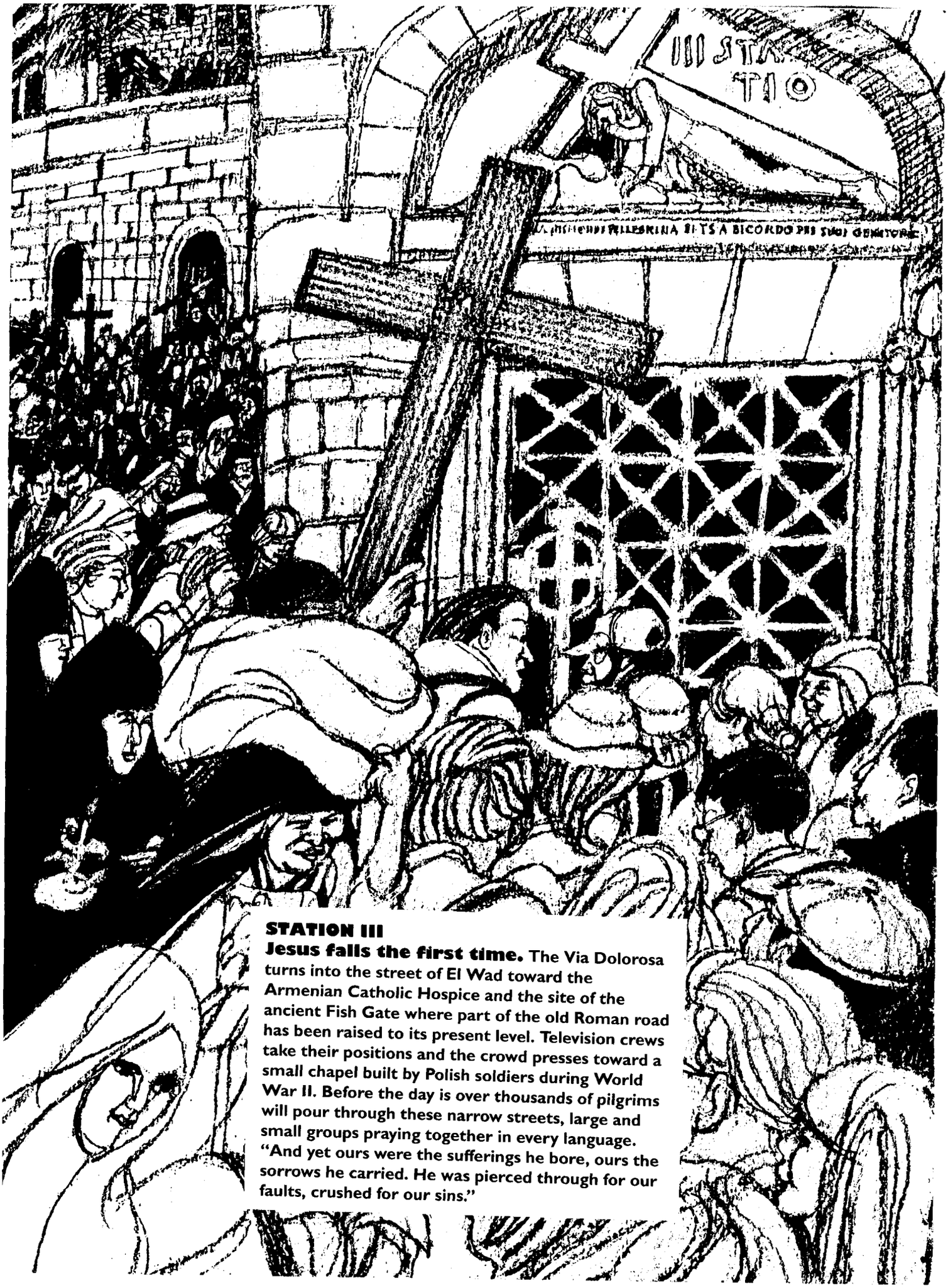

STATION III

Jesus falls the first time. The Via Dolorosa turns into the street of El Wad toward the Armenian Catholic Hospice and the site of the ancient Fish Gate where part of the old Roman road has been raised to its present level. Television crews take their positions and the crowd presses toward a small chapel built by Polish soldiers during World War II. Before the day is over thousands of pilgrims will pour through these narrow streets, large and small groups praying together in every language. "And yet ours were the sufferings he bore, ours the sorrows he carried. He was pierced through for our faults, crushed for our sins."

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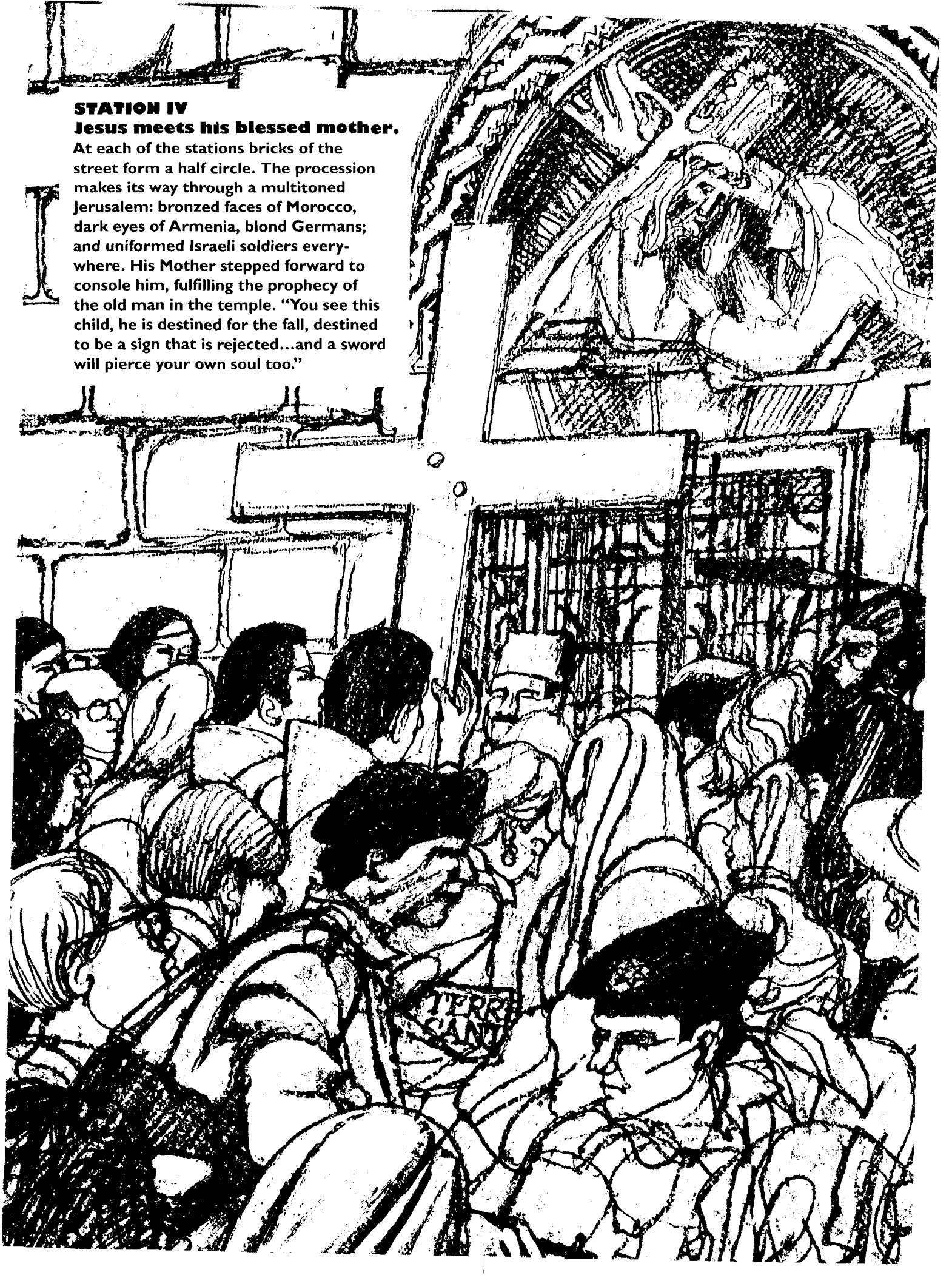

STATION IV
Jesus meets his blessed mother.

At each of the stations bricks of the street form a half circle. The procession makes its way through a multitoned Jerusalem: bronzed faces of Morocco, dark eyes of Armenia, blond Germans; and uniformed Israeli soldiers everywhere. His Mother stepped forward to console him, fulfilling the prophecy of the old man in the temple. "You see this child, he is destined for the fall, destined to be a sign that is rejected…and a sword will pierce your own soul too."

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STATION XIV
Jesus is laid in the sepulcher.
The faithful return to ground level, pass the place of anointing, and enter the central part of the Basilica. This is the Holy Sepulcher. A Greek Orthodox procession, followed by Syrians and Copts, passes the chamber where the body was laid on a stone couch. "They took the body of Jesus and wrapped it with spices in linen cloths, following the Jewish burial custom. At the place he had been crucified there was a garden, and in this garden a new tomb in which no one had yet been buried."

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(Continued from page 14)

I know when he was younger the kids used to give him a hard time about that. He walks with a limp, and I remember girls laughing and imitating him. I think that's the most painful kind of experience, when people don't understand." She is anxious about the possibility of more bad health befalling him. His limp is the result of a clot that formed around the shunt he had during the transplant, so that blood could be drawn and medications administered. The clot extended into the arteries, Rappeport says, preventing one leg from growing properly for a while. And then when he was in sixth grade, Patrick developed a leg tumor that looked malignant but turned out to be benign. Though this happened long after the transplant, it was a terrible scare. Wiskott-Aldrich patients sometimes die of tumors, as well as from bleeding and infection, and people who have had bone marrow transplants sometimes develop tumors as a result of the immunosuppression of chemotherapy and radiation. Surgery to remove the tumor caused excruciating pain. Patrick wouldn't let visitors touch the bed he was in, let alone touch him. He also had cataracts, almost surely because of radiation. And despite his normal, perhaps high, intelligence, he has trouble reading and writing because of learning disabilities, presumably caused by the battering his body took so he could live.

Now in his late teens, Patrick is healthy, but he is short, also presumably as a result of the radiation he received. He is about five feet, two inches, though his mother and father are both tall and Beverly is six feet. Scott is a huge guy, six foot six, a professional football player. Patrick, too, likes sports. He shoots baskets, plays floor hockey, wrestles. He thinks he would like to be a gym teacher, perhaps for special-needs kids. It's work he likes; he baby-sits for two retarded people, twins.

Of the doctors Pam says, "they were all very good." But right through her telling she indicates, sometimes just with a hand gesture, a seconds-long imitation of the dismissal or brusqueness or lack of feeling she endured under the more or less constantly horrendous conditions of drawn-out critical, but potentially curable, illness. "It was awful," Pam says. Beverly, talking separately, agrees, "I can't explain it. It was awful."

Patrick is quiet and gentle. But, says Beverly, "he has a lot to say. He likes to talk and has a lot of feelings and a lot of emotions, but he never just lets himself go and says it. He'll talk to me, because we have this weird connection." She doesn't know if it has anything to do with her having been his donor, but she says, "We're really, really close. I could sit and talk with Patrick for hours and hours and hours, and we won't get bored. He's smart. He can do anything. And whatever he does, he'll do well. Because he wants it so bad. I don't know if it has all come from his past experiences or whatever. But he's very, very determined. He doesn't get discouraged."

Rappeport's unwillingness to allow himself to become discouraged saved Patrick Hough. He says the Wiskott-Aldrich experience was, in a way, like gene transfer—the technology-in-the-making where defective cells are extracted, altered to make them healthy, and reinserted. "You're taking an exogenous source of the gene—cloned by mother nature, rather than in the laboratory," says Rappeport, "but you are putting in a new gene." Rappeport believes his success with Wiskott-Aldrich syndrome is representative of a kind of experience that he sees as virtuous, endangered, and necessary: clinical research—learning through the attempt to cure.

The Houghs' story is the reality of medical and scientific progress. Solutions often don't come smoothly or easily, and can involve uncertainty and terrible suffering. All the choices can seem untenable. Christopher's death, after a short lifetime of pain and sickness, was a tragic, heart-breaking fate for him and his whole family. (The Houghs are now divorced.) The outcome for Patrick, despite the difficulties and hardships he's had, is infinitely preferable. Abortion is unacceptable to many people, and, in any case, ineffective against many of the extreme misfortunes of catastrophic illness. It's important to remember, too, that palliative treatment, such as that given Christopher Hough, can be more expensive—financially as well as emotionally—than that which is curative.

It's awful to have a bone marrow transplant. And yet, since 1976 Rappeport has transplanted a number of children with Wiskott-Aldrich syndrome and, with the exception of one boy whose donor was a genetic half-match, all are now healthy. Other doctors in other places have used the procedure to cure many more children. In the intervening years, too, hospital stays have been gradually reduced for bone marrow transplants, and the therapy's applicability has been broadened; more and more lives are being saved, often with less financial cost and less agony than used to be the case. More is known: about blood, about genetics, about all of biology. Science does lead to the cure of dreadful disease. We cannot let our fear of the unknown, and our well-founded skepticism and frustration at human inadequacy, make us turn away from the effort to save life, especially young life. That effort, bringing hope, is surely a necessary and virtuous thing. □

Timothy Hodor

The Narcissus Bone

Life sowed time on me,
Scattered seeds on my flesh,

Gave me blossoms,
And irrigated my blood.

I search for that colored marrow
My memory suspended in spring.

I see them,
These flowers of my being

That float in shadows of the wind:
The air has wilted.

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BECOMING A STATISTIC

MEDICAL RISK & ERROR

JOHN LYNCH

From my bed in a Boston hospital I looked up at three seriously unsmiling doctors. I had never seen them before, and I was vaguely aware that they had asked my wife to leave the room. "Can you say 'Methodist-Episcopal?'" one of them asked.

"Methodist-Episcopal," I replied after a moment, propping myself on my elbows, realizing that I was probably only partly fulfilling the request. "What's—that—all—about?" My words came slowly and awkwardly.

"You've had a stroke," the doctor said, "and if you can say 'Methodist-Episcopal,' which is fairly difficult, that may tell us something about your condition."

My condition was that I had thrown up all over my bed hardly a half hour earlier, my speech was slurred, the facial muscles on my left side sagged, my left hand was not entirely useful, my blood presure was or had been 200 over 100 (nitroglycerine patches had been hurriedly applied to my chest and I was started on Procardia) and I badly needed to urinate but could not.

"Can you touch your left fingertips with the thumb of your left hand?" a second doctor asked.

My thumb struggled toward my first finger, but the others were orbiting somewhere out in space.

"No," I said, which was plain enough, and I lay back on my pillow, in some pain and considerable confusion.

Three months earlier I had what were described as, for lack of a more fitting term, two "interim seizures." One had happened when I was driving on Boston's circuitous, heavily traveled Route 128. The car had begun weaving over the white line and, although I was wide awake and aware that it was, I was helpless to control it. Only when my wife, who was beside me, jabbed me in the side, did I bring the car under control. The other happened at venerable Fenway Park, where we were attending a night game between the Boston Red Sox and the Kansas City Royals.

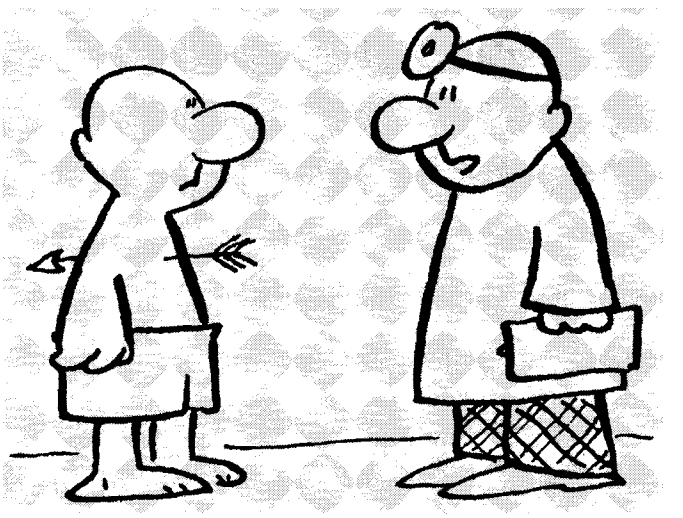
When two Red Sox shortstops in a row came up to bat, I turned to my wife and remarked that the Boston pitcher was coming out because a pinch hitter had come in. After the Red Sox had finished the inning, I saw that, strangely, the pitcher was still in—and then I realized that the earlier shortstop had batted for Kansas City and between the two opposing shortstops I had lost four or five players, possibly an entire inning. Not connecting the two "seizures," I drove home, although somewhat sobered by the occurrence. My wife said that the flu was going around, but I knew it was something other than the flu.

My doctor recommended a Computerized Tomography (CT) scan, which "showed an abnormality which was consistent with an aneurysm of the middle cerebral artery." I was turned over to a neurologist, who scheduled Magnetic Resonance Imaging (MRI) at a nearby suburban clinic.

Meanwhile, to stave off any additional seizures—if that is what they were—I was put on the drug Dilantin, which, the doctor assured me, would have few side effects. I broke into a rash, my speech slurred, my hands trembled, and I was soon rid of the Dilantin, but then put on Tegretol, which, I was told, had no side effects. When I began hallucinating, I was taken off of that too.

The MRI report read, in part: "Unusual appearance of the internal carotid artery on the right and the right middle cerebral artery with a tri-lobed flow void seen in the distal aspect of the M-I stem. The findings are highly suggestive of an aneurysm but also the possibility of a tortuous and ectatic internal carotid artery and right middle cerebral artery is raised. Angiography would be required for definitive assessment." The term "angiography" meant little at the time and I viewed it as yet another procedure.

Since there was now a definite indication of a brain aneurysm, I was recommended to the care of a Boston hospital, where, if events followed their probable course, I would undergo brain



"When did you first notice the symptoms?"

JOHN LYNCH, *a regular contributor to* Commonweal *in the 1950s, lives in Framingham, Massachusetts.*

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surgery. At the hospital I met with a staff neurologist who thought a second MRI was called for, using a hospital machine that was said to be five times more accurate than the one at the suburban clinic. In conversation with my earlier neurologist, he indicated that the more advanced machine, in the opinion of some physicians, had not yet been proven, but there was no harm in getting a further view. More than two months had now elapsed since the CT scan, so it appeared that at least there was no sense of urgency, and that was to the good. But the first indication that not everything was in sync came when the hospital neurologist asked me to get an appointment with him as soon as possible after the MRI and he would go over the results. When I spoke with his appointments secretary, however, she said that the doctor was going on vacation and the earliest appointment after the MRI could not be for more than three weeks.

The second MRI confirmed what was known from the first and I was scheduled to meet with a brain surgeon a week later. Forget the vacationing neurologist. Again I noted no sense of urgency. Holding a model of a skull in his hands, the surgeon detailed how he would cut my skull open and flap the bones aside, then "slice" through my brain to locate the aneurysm, to which he would fix a metal clamp and narrow the bulging artery. But first he had to get a detailed picture of my brain and a "road map," in his words, to the area of the aneurysm, and this would require a cerebral angiogram.

During this procedure a contrast dye would be injected through a thirty-nine-inch-long catheter running through my arteries from a small incision in my groin, across my chest and up my neck. A thin, flexible wire would be passed through the catheter to explore the area of the aneurysm, all the while being monitored on television. When the proper location to receive the dye was located, the wire would be withdrawn and the dye injected. A series of x-ray pictures would be taken to provide a permanent record of what appeared on the monitoring television. When the dye was injected, according to a handout given me, I might feel a "warm, flushed feeling."

Five days later I went to the hospital for blood tests and to meet the doctor who would be doing the angiogram. Because the procedure involved an "acceptable risk," I was asked to sign a consent form, a routine business. Sometime during the discussion, however, I seem to remember the doctor mentioning that there was a 1 percent chance of stroke, but the word didn't jar me. What was stroke but something that involved people with high blood pressure, high cholesterol, a history of smoking and other bad habits. Later I found that the literature had its own language, a stroke being a "cerebrovascular accident" or an "ischemic event." True, I was sixty-eight years old, but I was in general good health.

The day following the blood tests, my wife and I arrived at the hospital before 8 A.M. and were told to go directly to the angiographic suite. Within minutes I was telling my wife goodbye and saying I would see her upstairs, as angiogram patients were required to stay overnight.

I climbed onto an x-ray table and was given a sedative. An intravenous (IV) system was hooked up to a needle taped to a vein in the back of my left hand. Because I needed to be awake to receive instructions and to otherwise communicate, there was no anesthetic. Immediately as the IV fluids began to flow, they also began to leak onto the table through a broken connection, and the system had to be carried to the other side of the table and a new needle inserted in the back of my right hand. At this time I also noticed that the doctor pulling on latex gloves was not the person whom I had met the day before. I introduced myself and he introduced himself and said that two doctors would be working the procedure together.

I felt the slight nick of the incision in my groin and we were under way. There was actually no discomfort for most of the angiogram, but when a streak of flame seemed to scream past my left eyeball and there were flashes like fireworks, it was discomforting to say the least. By no means was it a "warm, flushed feeling." I was then told to lie with my head back and they would take x-rays from under my chin. When that position was attained I felt a jolt through my right eyeball many times hotter than through the left, unimaginable flashes of light, and pain like I had never experienced before. It was at that point, I believe, that I became a statistic, the one out of a hundred who suffered an induced stroke.

Although I was not aware of all that was going on, I do remember that the nurse said to the doctors that I had begun to slur my speech. But soon word came from the x-ray monitoring room (in the voice of the brain surgeon) that there hadn't been an aneurysm after all and there would be no surgery required. The later, technical "Discharge Summary" noted: "His angiogram showed a right MCA bifurcation tortuosity of vessels but without aneurysm."

In the procedure, however, as was explained to me later, something had dislodged a bit of plaque from inside an artery and it had broken loose and blocked the artery, causing all the brain cells beyond that point to die. It could have been caused by the tip of the flexible wire or even the surge of the dye.

But to a more mysterious matter. In the "Discharge Summary" (written after four days in the hospital, not just overnight), there are these words: "The general physical exam immediately post angiography revealed...He was noted to be speaking with slurred speech. The cranial nerve exam revealed a left sided facial droop, the motor exam revealed decreased strength to the left upper extremity. The sensory exam revealed decreased pin prick in the left upper extremity." Yet, with these signs, it was decided that there had been no stroke and I was released to my room upstairs. What my disability was apparently attributed to was some unknown combination of drugs or trauma. When I requested a meeting two weeks later with the initial doctor who had been going to do the angiogram—the one who interviewed me—he said they certainly would not have sent me to my room if they had in any way suspected a stroke. The stroke, he insisted, had occurred sometime during the afternoon, after I had become settled in my room. The "Discharge Summary," in fact, continues: "The episode of left sided facial droop and left sided weakness occurred approximately 1-2 hours after the angiography was performed....The impression was that the patient suffered an

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IT'S THAT TIME AGAIN

Last year we received a magnificently brilliant communication from the brilliantly magnificent academic vice-president of a pre-eminently foremost East Coast Catholic university. Excerpts:
"I am following up on our recent phone conversation and am enclosing the names of ten graduating seniors...that I am requesting you enroll as subscribers for one year."
This was followed by a list of ten names with addresses, tastefully arranged on the page. Then, our almost favorite sentence:
"Would you kindly bill me for $360."
And here's the topper:
"High among the desired outcomes of this little exercise is that the graduates will become lifelong readers of COMMONWEAL. My best wishes to you."
In the coming weeks graduates of colleges, universities, seminaries, and divinity schools will be wandering out into the real world. They, too, will need their COMMONWEALs, don't you think?
We certainly need them. Please consider using the coupon below to give a gift subscription to your favorite graduate.
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ischemic event of the right side." Unexplained is the time discrepancy between the revelations of the physical exam immediately after the angiography and the discovery of the "episode" during the afternoon. The initial doctor involved in the angiogram declared he did not even know an exam had been given until he was made aware of it by the "Summary," and guessed it may have been conducted by "some intern on the floor." Discouragingly enough, four months after the angiogram, in reply to an inquiry of mine, the hospital admitted it had yet to identify the doctor who had given me the physical exam.

In any case, when my wife arrived in the room—they had forgotten to notify her when I went upstairs and she had to seek out the information herself—a lunch tray was on hand and the nurse, not having been informed of the stroke (for no one said it was a stroke at that time), told my wife she could feed me. That was when I threw up. And luckily, or I might have choked or drowned.

When two other doctors entered the room, one said, "Say: 'Methodist-Episcopal,'" and the next day when two student nurses came in with clipboards and pens, one asked, "Can you say 'Methodist-Episcopal?'" By that time I was on cue.

Sometime toward evening of the first day, a nurse came in with her kit and before God and all of my family was soon threading a catheter into my bladder. I don't know what hurt more, the pain or the indignity.

Confusion of one sort or another continued. A technician on the second day came to draw blood and noticed that I was not wearing my ID bracelet and refused to take the blood, although earlier technicians had. It is possible that during the change in the angiographic room, the nurse who had cut the IV bandages from my left hand had also inadvertently cut off the bracelet. It is one of the lesser mysteries.

Curiously, several of the doctors asked if I was left-handed and, if not, was it possible I had been born left-handed and my parents had trained me to be right-handed. This, they said, might explain the fact that I was right-brain damaged but I had slurred speech, which is normally associated with left-brain damage. It also might explain—although I find this sloppy thinking—why the slurred speech noted in the angiographic room was not suspected as stroke-related but of some other origin. Later I was told by a speech therapist that I fell into the 2 percent of stroke victims who were cross-handed. But since this phenomenon is known, why was there no method in place to catch the 2 percent? Indeed the "Summary" notes: "neurology was consulted. Their impression was again a right-sided ischemic event in a patient with probable crossed aphasia."

Perhaps of less importance was the observation that "over the course of twenty-four hours, his neurological exam was noted to be significant for a left upgoing toe."

During the first night in the hospital, rows of German soldiers marched across the darkened TV screen hung on the wall. Soon the hospital was on fire and I tried to leave my room and escape. The hallucinations did not cease until dawn. The following night it was soldiers in El Salvador moving out of the TV set.

I attempted to read, but I could make little connection between

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adjoining paragraphs, and only the centers of newspaper columns made any sense, the edges right and left were incomprehensible. My words were embarrassingly slurred and I kept biting my lip when I ate.

During the afternoon of the second day, when I was alone in my room, a young doctor stood by the bed, took my hand for a minute and said, "I'm sorry." He was the doctor I had seen putting on the gloves, who had actually made the incision and directed the catheter into my brain. At no other time did anyone else among the dozen or more staff who attended me approach my bed to say, "I'm sorry."

In the days following I was given another CT scan, an echocardiagram and a final MRI. I was then discharged with no instructions other than to see a speech therapist, and that I should improve rapidly. I was cautioned not to drive and I was given a prescription for Tegretol, which I never filled. The interim seizures, or whatever they were, were seemingly no longer of importance and were forgotten.

My wife obtained two books on stroke from the library and the speech therapist provided some literature. No one suggested that in six weeks I would be seeing a psychologist, as the bottom dropped out of my life and I entered depression.

I wasn't sleeping well and time and space began playing tricks on me. I once told my wife that I had listened to a two-hour concert on the radio and it had taken me four hours to do it. I went to bed at 10:30 and rose expecting the dawn, when I saw it was not even midnight. I awoke six or seven times a night, wondering how long I had been asleep and invariably finding it had been an hour or less. A blue-grey haze spread through a supermarket one day and I nearly fainted while holding onto a shopping cart. What was going on?

I was in a state of siege. Periods of anxiety overtook me. I was disoriented. I was increasingly frightened to be alone. In the morning I trembled in my bed. I sought my wife's succor and found I had become impotent.

I felt that my brain had become short-circuited. When I described it to family and friends, I could use no better word than "discombobulated." When people asked questions, I could focus hazily on the subject but could not find the words to answer. That was it, I was discombobulated. I could see the words but I could not bring them in. When I became tired, I mumbled and stuttered. I avoided answering the telephone. I walked into furniture and door jambs and bookcases. I visited an opthamologist and was given a test for peripheral vision. I tried to use a typewriter but was so uncoordinated that the keys seemed to be not in their accustomed places. I had feelings of inadequacy. I was impatient with myself and imagined that people were impatient with me.

The speech therapist told me that my damaged brain could only process so much information and, when it became overloaded, it just shut down. What she didn't say was that, when my brain became fatigued, so did my body, and on several days I could barely manage to get out of bed, even for meals.

When I walked into furniture and door jambs and talked about it, my friends would say, "I always do that." They didn't always do it. When I told someone I had poured milk over a bowl of Ritz crackers and had taken it for breakfast cereal, he said, "Oh, I do that all the time." You also lie to keep my spirits up.

Friends now began telling me horror stories. My son-in-law's uncle had died on the table during an angiogram. A friend of my daughter's had been rendered brain-dead. I found no consolation here at all. I was told that at least I was alive, I could have been killed. A nurse said it was no big deal, people die all the time in hospitals. Don't be negative. Count my blessings.

A medical article in the *Boston Globe* reported that "Conventional angiograms are invasive procedures that carry a 6 percent risk of minor complications including hemorrhage and a 2.6 percent risk of major complications requiring corrective surgery.... About 3 in every 1,000 patients die from the procedure.... Some patients also have potentially fatal reactions from the dye."

A doctor was quoted as saying that, during angiograms of the head and neck blood vessels, he "used to sit there with patients and I was soaking wet because I was scared to death I was going to kill somebody—maybe give them a stroke or bump them off, and I didn't want to do that."

Robert Lee Mahon

The Specialist

One of the best diagnosticians in the profession,
When finally called in he correctly identified
The problem as Crohn's disease, a chronic inflammation

Of the bowels and intestine. "Very rare,"
He commented as he watched the surgeons excise yard after yard
Of her insides. "Not fifty cases of this severity in the literature."

Curious, he followed the case, even though identification
Obviously no longer posed a problem. She ended
Without a bowel, and with just three feet of lower intestine.

"We got it," his surgeon-colleagues officially exulted
On the way to their dictaphones. Of course, to stay alive,
Her guts having been reduced to entrance and exit,

The patient had to consume twenty thousand calories
Per day. A glutton's delight, this diet, sugar, carbohydrates, more
Sugar, a meal every two hours, constant snacks....He observed the calory-

Count, the constant mouth, the equally industrious anus.
He perceived the purity
Of it. After a few weeks, unable to eat properly, he took some
Pills. All the note said was: "Simplify, simplify."

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And then it began to turn around. As I write this, I am only sixteen weeks past the angiogram, but it has seemed like sixteen months, both to myself and to my wife. The days were never so long, the weeks with so many days. But time has kindly become more compressed. I still don't sleep well, but I have expunged most of the demons. I have been discharged by the speech therapist, but I still see the psychologist. I have been back to the hospital to see the neurologist. He warned me that periods of depression could beset me for another year or so, but I have decided not to believe him. Haltingly, I have begun to drive again. Sometimes I become confused at intersections where once I hadn't even bothered to read the street names. The impotency has reversed itself. I no longer bite my lip.

I bump into furniture less and less. Words still have a way of hiding, but they are not as far away as before. I no longer have to work at making sentences. And, although I have made several hundred corrections on these pages, I have managed to type this. □

SCREEN

SILLY SECRETS

'FRIENDS' & 'FINAL ANALYSIS'

Dennis Potter's *Secret Friends* is a jigsaw puzzle that doesn't give you much to look at once you've assembled it. Of course, the fun of jigsaw puzzles is in the assembly, not the final result. But *Secret Friends* fails as mind teaser, too, because too many of its narrative twists can be easily anticipated.This movie testifies more strongly to Potter's work ethic than to his art. For his first directorial effort, he's written a script that's very busy yet quite cold, extremely intricate, and utterly hollow.

The premise is interesting. A man on a train (Alan Bates) is quite obviously having an emotional breakdown. He weeps hysterically as he stares down at his luncheon fish but can't communicate to conductor and passengers the turmoil in his brain. As the film enters his mind we begin to understand that he fears he has murdered his wife (Gina Bellman) in a fit of insanity. Or has he merely imagined the deed? Until the last few minutes resolve the mystery, Potter devotes his story not to the immediate circumstances of the real or imagined crime, but to the reasons why such a murder *might* have been committed by this particular man.

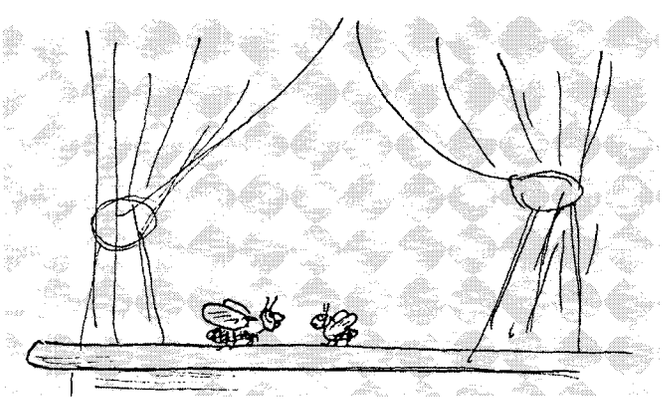
Potter's narrative method is one used in certain films of the 1960s and early '70s, all of which were inspired by *Last Year at Marienbad*: short, nonconsecutive scenes (sometimes no more than single-shot glimpses of an action) that don't unfold a linear story but challenge us to assemble the story ourselves. This method made sense in *Last Year* because that film was about doubt: how can we know if a love affair took place if the male affirms that it did while the female denies it? The method makes even more sense for *Secret Friends* because that subject is not only doubt (did Bates murder his wife or not?) but the sort of extreme anguish that can scramble chronology in the mind of the sufferer.

But making sense and giving pleasure are different things. By the end of *Secret Friends*, the puzzle pieces all fall into place but we couldn't care less. There seem to me two reasons why this is so.

First, the motives for the putative crime are all grounded in the neurosis of Bates's character. This is a man who cannot function sexually except in the arms of whores, yet who also harbors an extreme detestation of whorishness. Emotionally in love with his wife, he forces her to disguise herself as a call girl so that they can have sex, but then his feelings curdle murderously at the effectiveness of the disguise. But this is absolutely all there is to Bates's character. The psychosis isn't just an important component of the role, it *is* the role. Every scene, every flashback, every exchange of dialogue, relates to this sexual aberration, yet there is no exploration of it, only reiteration that the neurosis exists. This not only exhausts the viewer's patience but limits Alan Bates as an actor. With only one note to hit, he does his best to hit it with varying degrees of force, from different points of attack. Bates's virtuosity is impressive, but watching him here is like watching a great juggler discover how many ways he can juggle one ball. If Gina Bellman seems more lively, it's only because the script lets her contrast the behaviors of mousey wife and sexy prostitute, both of which she enacts admirably.

Second, Potter seems to underrate our ability at jigsaw-puzzle solving. He wastes so much time teasing us that he doesn't give himself enough time to open the characters up and make them truly complex and interesting. Long after we have guessed that the modestly dressed woman in Bates's home and the slit-skirted temptress in the London hotel are one and the same person, Potter is still trying to titillate us with identification games. And long after we have guessed that the phantom who looks exactly like Bates and who promises to do his murder for him is, in fact, Bates's imaginary doppelgänger (the "secret friend" of the title), Potter feels the need to explain the childhood origins of this double in a long, not very interesting monologue with which Bates embarrasses a dinner party.

There's so much fancy cinematic and narrative cakewalking in this movie that both the roots and the results of the hero's



"...and if a spider ever invites you to its parlor, don't go."

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problem are scanted. That old British standby, the puritanism of middle-class parents, is pressed into duty yet again as an explanation of what's wrong with the hero, and a nice heart-to-heart with the wife in bed seems to clear everything up at the end. All very tidy. And inadequate.

Did Potter, an enormously gifted writer ("Pennies from Heaven," *Dreamchild, Gorky Park,* "The Singing Detective") give himself this schematic script as an exercise so that he could worry less about characterization than about where to place actors and camera? If so, he certainly has come through creditably as a technician. The choice of camera angles, the duration of each shot, the alternation of fixed shots with long smooth pans, are all excellent. Now, if only Potter the talented writer would give his artistic doppelgänger, Potter the accomplished director, something interesting to work on! That would be a not-so-secret act of friendship from which we could all benefit.

Insecure males, take note! *Final Analysis* is the movie for you, especially if *Body Heat* left you feeling queasy. The latter film, you will recall, presented in its final reel a bewildered William Hurt taken completely to the cleaners by Kathleen Turner, whose brilliant scheming ensnared the poor booby into eliminating her husband and going to prison for it while Turner retired to the sands of Acapulco and the arms of beach boys. In *Final Analysis*, Kim Basinger almost tricks the psychiatrist played by Richard Gere into falling into the same sort of trap, but he brilliantly reverses the process in the last third of the movie, reducing her to the screaming meemies before she receives her final comeuppance. He even gets to lecture the poor murderess (on top of a lighthouse in a raging storm, no less) about how sick she is as the result of an episode of childhood incest. Then she falls into the Pacific ocean. If Susan Faludi ever puts out a second edition of her book about the backlash against feminism, *Final Analysis* should rate at least a footnote.

But does it work as a thriller? It does not. Phil Joanou's direction is so soporific that you watch even the high-tech action sequences in an uncaring daze. To his credit, though, he gets a surprisingly adequate performance from the beautiful beast Uma Thurman, by emphasizing her spaciness instead of trying to conceal it and by not giving her any speeches comprising more than two consecutive sentences. The gifted Eric Roberts lends the movie tension with another of his psycho-macho portraits, and an actor whose name I didn't jot down plays Gere's psychiatric mentor lovably as the reincarnation of Aaron Copland.

But Richard Gere and Kim Basinger must never, never, *never* act together again. This is at least the second movie they've made together (I had the misfortune to catch *No Mercy* on TV recently), so I assume they've been told by their handlers that their pairing is a triumph of star chemistry. But when a chemical reaction takes place, isn't energy given off?

What decisively sinks the movie is the script concocted by Wesley Strick, whose preposterous work on Scorseses's *Cape Fear* contributed to that film's odiousness. Strick doesn't plot; he just rams improbabilities together in order to create noise and bloodshed.

RICHARD ALLEVA

ART

SINGULAR BRUSH STROKES

THE ART OF SEMISI MAYA

The story begins with a single remarkable painting by an artist name Semisi Maya, improbably hanging in the otherwise forgettable lobby of the Travelodge Hotel in Suva, steamy capital of Fiji.

All I knew then was that I had stumbled upon someone who, in the confined space of a twelve-by-eighteen-inch piece of paper, could evoke the impenetrable tropical jungle in bold, slashing strokes with a palette of greens—someone who could paint in a way that made me momentarily forget that anyone had ever painted a jungle before. There was more of Maya's work stored in the back rooms of the hotel, as original in its vision as that jungle scene.

What I would learn about the man during my search to meet him in person made his work seem even more singular. For more than half a century, Semisi Maya has been wasting away from Hansen's disease—leprosy—which has kept him essentially confined and denied him the full use of the most taken-for-granted tools of the artist, his hands.

Fiji is barren ground for art. The tradition of craft, never as rich as in other corners of the South Pacific, has almost died out, and the hand-carved cannibal bowls that tourists bring home today are mostly made in the Philippines. Painting has never been a Fijian tradition, and what's on view is derivative of the worst of over-the-couch art. Semisi Maya's work is as remarkable as an eclipse. Not that he is unknown in his native land. A decade ago, several of his paintings had been made into postage stamps and others have graced the cover of the local phone book. But finding the man was harder. After several false starts, the helpful Visitors' Bureau located his address—P.J. Twomey Hospital, an institution for those afflicted with leprosy—and I set out to meet him.

No one stumbles upon Twomey Hospital accidentally. To get there, you leave the city miles behind and then, after passing a juvenile detention center surrounded by barbed wire, you turn down a rutted road to an out-of-sight building. The hospital, a clearing in the trees, looks as benign as an elementary school, all green concrete and covered walks, though there are incessant warnings about cleanliness and separate facilities for "ladies" and "gentlemen."

The affliction that keeps Twomey Hospital's twenty-two patients isolated seems, at once, as medieval as the plague and as modern as the AIDS ward. Historically, leprosy was a contagion of metaphor, a source of panic as much as an illness. But the development of successful regimes of treatment has made it seem less fearsome, as has a gradual popular understanding that it is spread only by prolonged skin-to-skin contact. Now the illness is called Hansen's disease, a name that carries no moral baggage, and the residents at Twomey are there not

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A metaphor for trust

When I set off in search of Semisi Maya, I was looking for an artist who incidentally had leprosy. To me, leprosy was just a name to describe the unfamiliar, a metaphor for shunning and isolation rather than a physical reality. I knew next to nothing about how the disease was transmitted, about the trajectory of illness, or about treatments.

When I pulled into the parking lot at Twomey Hospital, there were no other cars to be seen, no other outsiders. For the moment, the place was in the hands of the patients, and they were proceeding across the lawn toward me. At that second I realized why AIDS has been called the leprosy of our times: here was the thing itself, the source of the metaphor in all its disfiguring horror, and for a long moment I was panicky. Did I shake hands with these friendly, and perhaps deadly strangers, I wondered? Did I back off? embrace them? I looked longingly at my car and the prospect of flight that it offered; I had a flash of connection with those who, in the early days, saw AIDS only through eyes of dread.

The patients at Twomey were fifty feet away, then much closer, when I suddenly realized—intuited, really—that although I knew almost nothing about Hansen's disease, they knew everything that needed to be known. They understood which forms of intimacy were endangering, and which not. All I had to do was to follow their lead, trust them.

But what if they didn't know, a nagging interior voice persisted, or what if they were angry, moved by thoughts of revenging themselves against a world that put them here? The thought itself was its own rebuttal, too awful in its implications to govern my life. I couldn't imagine myself, the face in the mirror, as so distrustful and self-protective. Nervously but emphatically feeling a deeper kinship with the lepers real and metaphoric I returned the gentle hugs in kind, then went to meet Semisi Maya.

When I returned home, I learned from looking up Hansen's disease in a medical encyclopedia how hard it actually is to transmit the disease from one person to another. That knowledge came less as a relief than as confirmation of how things are.

D.K.

because they are obliged to be but because they have no place to go.

Only patients, no nurses or doctors, are on hand when I arrive. A dozen or so crowd around, children as well as old men, marked by purple blotches and disfiguring scars and wrecked bodies reminiscent of the rages of Kaposi's sarcoma. They walk gingerly, for the affliction destroys the nerves, gradually causing paralysis in many who are afflicted. Some have surrendered their hands or arms or legs to the disease.

In 1938, when he was a young fisherman living in the village of Cautata some twenty miles north of Suva, Semisi Maya contracted leprosy. He was first sent away to Makogai, a remote island which at the time served as Fiji's leprosarium, for fourteen years. Then he returned to his village, but the crippling effects of the disease forced him back to the hospital. Gradually his body weakened until, by the time he was forty, his fingers could hardly hold even the lightest object. That was when the Missionary Sisters of the Society of Mary who, then as now, run the leprosarium, proposed to the startled patient that he take up painting.

"Perhaps it was my manner," he says, "the way I described things. Now the manner becomes the man." The nuns tell the story differently. Painting was to be a counterweight to Maya's bouts of depression. "How can I paint?" he asked the sisters, pointing at his wasted hands. They brought books that showed Maya how other artists had overcome physical debilities, had worked with brushes held in their teeth or clenched in their toes.

By clasping his wrists together, Semisi Maya could barely hold a brush. His first paintings, he remembers, were "just noise" and there was no teacher to help, just the enthusiasm of the nuns. Gradually, though, Maya was able to recall on canvas moments from his childhood or draw on his Methodist upbringing to place biblical figures in the fields and jungles of Fiji—the Madonna, or Joseph the carpenter wearing the man's traditional skirt.

But even as his painting got better the degenerative effects of the disease grew worse. In 1982, Maya left Fiji for the first time. His work had received international notice, including a show at London's Bond Street Gallery, and now he was going abroad to see his paintings hung in a New Zealand exhibition. But he was going, mostly, to have both his legs amputated.

In his fastidiously tidy studio at Twomey Hospital hang a few of the old oil paintings. "But I am not so interested in oils any more," he tells me. "It has become much harder to hold the brush."

Now Maya has found another medium. That jungle scene I first saw, like scores of other works kept in the studio for the occasional visitor, are finger-paintings. He spreads the paint with the side of his forearm, then uses not just his fingers and palms but all the parts of his hands that he can manipulate, knuckles and the back of his wrist, the edge of his hand, and even the hair on his arms, to produce his effects, adding finishing details with a rubber-tipped spatula that he holds between his matchstick wrists.

What Maya has done transforms a way of making art that has been the province of enthusiastic six-year-olds. His purple and orange sunsets have the brilliance of American Luminist paintings. Hibiscus declare themselves with a delicacy that allows the dewdrop to drip slowly from the petal. The underwater scenes

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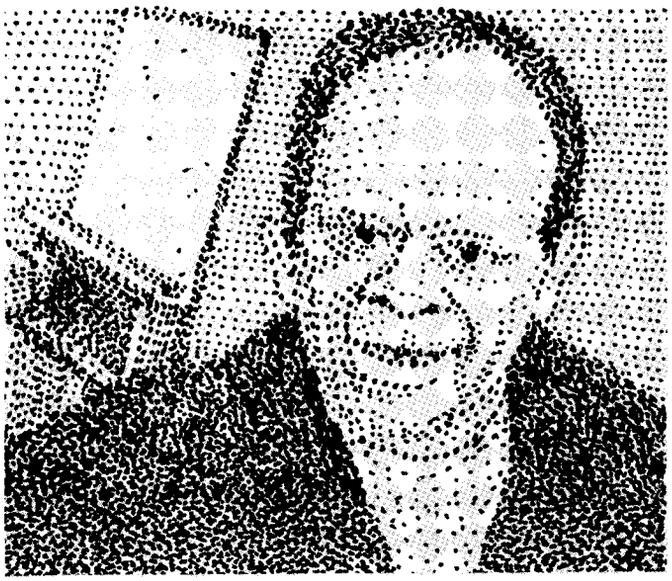
show waving, soft coral and fish that are sharply angular, even cubist. Those tableaux are softened as through the gaze of a diver's eyes, lighted as if by the pale rays of an end-of-the-day sun shining through the water. "I was a fisherman," Maya reminds me, "and I love the sea."

But Maya hasn't seen the sea for years, or flowers, or even sunsets. He has to rely on memory and photographic reminders to "think my way back to the place." "It is not a good life," he says. "It is a painful life. The sisters say, 'think about your art, don't think about the pain.' But I can't go where I want to go, and when I am angry, I cannot work." While he is patient with his visitor, retelling the story of his life, when I ask about taking his picture he says sardonically, "don't expect me to stand up."

Other patients come by to watch him paint but none has taken him up on his offer to teach them how. "Too much work," they say. These days, Semisi Maya paints every Tuesday, when a former patient comes to help him mix his paints and soak the paper. He works steadily, three hours in the morning and three hours in the afternoon. He will turn out as many as a dozen paintings in a single day, hundreds each year, thousands over the decades since the sisters put a brush between his wrists, a record of a place whose surpassing beauty has never been captured in painted images.

Maya sells his paintings for a pittance, $20 or $25 apiece, the price varying with the size, and he uses the money mostly



for paint and paper. Some of those paintings eventually find their way into otherwise forgettable hotel lobbies, where they lie wait to prize open the eyes of a passing stranger.

DAVID L. KIRP

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BOOKS

Catastrophes in the planning

WHAT IS TO BE DONE
Proposals for the Soviet Transition to the Market
Merton J. Peck and Thomas J. Richardson, eds.
Yale University Press, $12, 220 pp.

John Feffer

As it sinks further into recession, losing considerable ground to Europe and Asia, the United States still maintains a comparative advantage in one dubious category: faulty economic models. The laissez-faire school—Milton Friedman and the other progenitors of Reaganomics—exported its model to Latin America in the 1970s and 1980s with decidedly mixed results. The recent fall of communism has provided these social scientists with a vast new laboratory for experimentation. Repackaging their prescriptions as "shock therapy" and counting on the considerable assistance of Western governments and multilateral lenders, these missionaries of monetarism brought their brand of economic reform first to Poland and then to the rest of Eastern Europe.

The results have been devastating. Eastern Europe today is mired in a deepening depression complete with inflation, unemployment, and social misery. Institutions ranging from the United Nations to the investment firm of Morgan Stanley have warned of a grimmer future and consequently have urged new economic strategies for the region.

Meanwhile, somewhat further to the east, the Soviet Union has fragmented into fifteen independent states (and counting), each new nation poised to move from centralized planning to the market. With the experience of Eastern Europe so visibly negative, you might think that the post-Soviet states would steer clear of U.S. economists peddling their wares. And you might think further that U.S. economists would be revising their models in light of the manifest problems of shock therapy.

Wrong on both counts.

Boris Yeltsin and the new Russian government, for instance, have solicited the economic advice of the same U.S. economists who developed the Polish model.

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And those economists, if the recent study *What Is To Be Done* is any indication, have barely altered their message.

The project that culminated in *What Is to Be Done* began in 1989 when a group of economists organized by Yale University turned its attention to the Soviet economy. Although written immediately before the August 1991 coup and the subsequent dissolution of the Soviet Union, the Yale report nonetheless remains characteristic of economic approaches to post-Soviet economic transition. Therefore, despite the solid credentials of the participants—Alfred Kahn, Alice Rivlin, John Williamson, and several international scholars—this consensus document disregards not only the theoretical flaws of rapid reform, but the contradictory evidence provided by reports out of Eastern Europe today.

Like the Lenin and Chernyshevsky works from which it takes its title, *What Is to Be Done* reads more like a manifesto than a sober assessment. Coming from economists, the suggestions are predictably rather dry. But the call to arms is nevertheless radical. Prices should be liberalized overnight, the document's framers insist. State enterprises must be privatized, government spending cut, the domestic economy internationalized, and last (and sadly least) the negative social impact minimized. Reform is to be instituted from above and no provisions are to be made for enlisting popular participation in reshaping the economy.

Some of the report's suggestions are eminently reasonable. The post-Soviet governments cannot, for instance, afford to continue subsidizing consumer prices. So too must these new countries adapt themselves to the world economy. Other prescriptions, however, are simply inaccurate. The notion of a "ruble overhang" —an excessive number of rubles held by the population—no longer exists. When the Soviet Union instituted mild price reforms in April 1991, most of the rubles disappeared as consumers began to draw on their savings to supplement their falling wages (a similar phenomenon occurred in Poland in 1990). Thus it is wrong to suggest that the post-Soviet population can survive another massive price increase by spending their excess rubles. To imagine that the average post-Soviet will still have some money left over to buy shares in newly privatized industries—another *What Is to Be Done* proposal—requires even greater credulity.

But like Reaganomics and the laissez-faire remedies offered to Pinochet in Chile in the 1970s, the model outlined in *What Is to Be Done* errs not so much in the details but in its overall conception of an idealized market. The government should play only a minimal role in the economy, insist the shock therapists: the market must be allowed to solve all problems. Thus do the new pundits disregard not only Keynesian insights but the very dynamics of capitalist economic development as well. It was precisely through government support that the currently successful Asian economies—Japan, Korea—developed in the postwar era. Even the United States grew economically in the nineteenth and twentieth centuries by cultivating industries and agriculture behind government-established trade barriers.

The state unquestionably played a ruinous role in the Soviet economy. But this does not justify rushing blindly to the other extreme. The post-Soviet governments can and should still regulate the economy, constructing an industrial policy that allocates resources to promising industries, negotiating favorable trade terms that permit the growth of domestic producers, establishing a progressive tax structure that minimizes large inequalities in wealth, judiciously distributing foreign aid.

True, the economists involved in *What Is to Be Done* do emphasize the need for social welfare programs. But even here, they emphasize unemployment benefits and not job retraining, market-based solutions and not coordination between government and labor. Even foreign aid, so critical in avoiding widespread deprivation, is dismissed almost categorically. Much as the proponents of trickle-down insist that welfare spending is money down the drain, these economists argue that foreign aid would accentuate rather than alleviate the problems.

By presenting their version of austerity capitalism as the new orthodoxy, the economists associated with *What Is to Be Done* are priming the post-Soviet Union for a catastrophe equal to or worse than Eastern Europe's. It is a sad comment indeed if in place of Marshall Plans, we now only send Reaganomics. Perhaps there is a new economic law at work here. If it don't work, don't fix it. Export it. □

I HEAR AMERICA RHYMING

THE BEST AMERICAN POETRY 1991
Mark Strand, Editor
Collier Books, $12.95, 326 pp.

Suzanne Keen

The Best American Poetry has become one of autumn's events. Since a different poet guest-edits each annual volume, the series provides both familiar pleasures and a refreshingly individual look at "the best" of an abundant harvest. Previous volumes, edited by John Ashbery (1988), Donald Hall (1989), and Jorie Graham (1990), have given readers a look at about seventy-five poems, gleaned from the year's journals. That its publishers can claim best-seller status for the series (it makes the lists compiled from independent bookstores) suggests that Americans *do* read poetry, especially when it is intelligently selected and attractively packaged.

Mark Strand introduces the 1991 volume with a poignant essay about his parents, who did not really understand his vocation. His mother, he reports, "was not a reader of poetry." After her death, his father begins to see what poetry is *for*: "He can read my poems ... and be in possession of his loss instead of being possessed by it." Although Strand celebrates language's ability to enchant and admires poetry's evasion of final, certain meanings, he insists on its function in our lives: "The way poetry has

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of setting our internal houses in order, of formalizing emotion difficult to articulate, is one of the reasons we still depend on it in moments of crisis and during those times when it is important that we know in so many words what we are going through."

The Best American Poetry 1991 gives its readers an admirable map of what we are going through. It provides diverse perspectives and interesting congruences, such as the appearance of the figure, in several very different poems, of a homeless person, as in Allen Grossman's "The Ether Dome (An Entertainment)": "...It is Autumn/ In America. And there is a body / On the path in the Public Garden." Robert Kelly's "A Flower for the New Year" contains this blunt reminder of suffering: "...and I sit here baffled by the name of purple flowers, remembering all the girls in my life as they step naked-footed lewdly up the chill sedate corridors of the marble museum of my heart, I worship their nakedness while some man lies in the snow on Sixth Avenue with no shoes."

The terrain explored by poems in this volume includes the harrowing scenes of Carolyn Forche's "The Recording Angel," Alice Fulton's imaginative "The Fractal Lanes," and David Trinidad's amusing set of seventeen haiku based on old TV shows, "Reruns." Joyce Carol Oates's "Edward Hopper's *Nighthawks*, 1942" imagines the situation and thoughts of the woman at the counter, while the preceding poem, Thylias Moss's "Lunchcounter Freedom," wrenches another American scene out of its place in documentary and reinvests it with an individual consciousness: "Because I'm nonviolent I don't act or react. When knocked from the stool my body takes its shape from what it falls into. The white man cradles his tar baby. Each magus in turn. He fathered it, it looks just like him, the spitting image. He can't let go of his future. The menu offers tuna fish, grits, beef in a sauce like desire. He is free to choose from available choices. The asterisk marks the special."

David Lehman, the general editor of the series, finds "every reason to rejoice in the diversity that seems inevitably to emerge" from the process of seeking seventy-five poems out of the thousands published in periodicals in a year. The forms and kinds of poetry in the volume impress not merely by their variety but by their vitality. The very long line is represented not only by Ashbery's "Of Dreams and Dreaming," but by Gerald Burns's "Double Sonnet for Mickey," which delivers two scoops of rhymes in the Elizabethan pattern at the end of lines so long they defy the ear's expectation of fulfillment. Among stanza-shapes used by the poets, triplets abound. The fourteen poems written in three-line stanzas surprisingly outnumber poems in quatrains. The extraordinary subtlety and flexibility of Derek Walcott's tercets stand out, although the excerpt from *Omeros* only gives us a hint of their cumulative effect in the book-length poem.

Admittedly, very long poems present anthologists with an insoluble difficulty; they must either excerpt or omit. Mark Strand earns my gratitude for printing sequences and long poems in their entirety. To have all the parts of David Shapiro's "The Seasons," for instance, allows the reader fully to enjoy the villanelle, "Drawing after Summer," that closes the sequence by recycling lines from the preceding poems into a chilling *envoi*: "The moon moves outward failing to grip the roadway. I see you stuck in the ground like a dictionary. I saw the ruins of poetry, of a poetry. I approach your metal mouth, you put it close to me."

Shapiro's comment on his sequence

REVIEWERS

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Symposium on the
Lutheran/Catholic Dialogues:
"The One Mediator, the Saints, and Mary."

July 7-9, 1992

Speakers: **Fr. Avery Dulles, SJ**
Fordham University
Dr. Eric Gritsch
Lutheran Theological Seminary

Responders: **Dr. J. Robert Wright,** Episcopalian
Dr. Donald Dawe, Presbyterian
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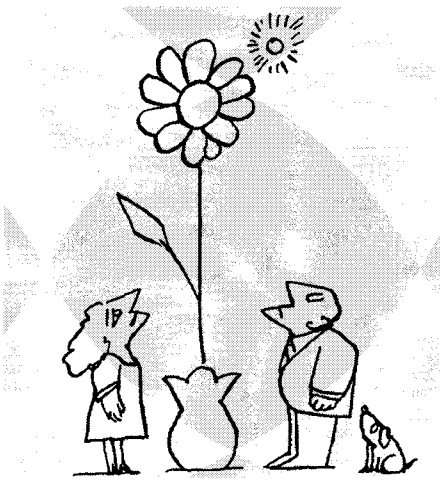

reveals that "the villanelle is an attempt to mimic [Jasper] Johns's aristocratic ink details 'after' his own painting." To find in the Contributors' Notes and Comments this and other information—traces and sources, contexts and glosses, methods, intentions, and occasional rebuffs to our curiosity—is in itself one of the most interesting features of *The Best American Poetry*. Expanding these notes beyond the routine résumé of publications and honors gives the series a real way of demonstrating what the editors assert: there's a whole lot more good poetry, to be enjoyed and taken seriously, out there.

Any collection that purports to bring together the "best" of anything can be criticized for its omissions, but this volume so elaborately directs our attention to "all the rest" that I can scarcely fault it. The list of addresses of the journals from which the poems come reminds readers that poetry publishers, as well as poets, exist all over America and that you don't need to live near a big city bookstore to get your hands on their magazines. □

IN BRIEF

KOOP: THE MEMOIRS OF AMERICA'S FAMILY DOCTOR, *by C. Everett Koop, M.D., Random House, $22.50, 320 pp.*

The best-known of modern surgeons general, Everett Koop has surely been among the most influential physicians of our time. Chosen by the Reagan administration because of his unrelenting crusade against abortion, this "born again" evangelical Christian found his epiphany, paradoxically enough, in the explosive onslaught of AIDS. Talking of sexual practices and devices did not come easy for him, but, as he might put it, Christian love triumphed over hatred of the sin. Making condoms respectable as well as ubiquitous may rank with the decadence of ancient Rome, but Koop overcame his instincts and training to rise up against the AIDS epidemic. In the history of our time that will loom more important even than his campaign against cigarette smoking. To stand aside and let someone die may not look like murder to ethicists, but physicians have a hard time with inaction.

For the most part Everett Koop has fought the good fight, and deserves our gratitude and praise. From his operating room to the bully pulpit of his office as surgeon general, Koop has been an activist as well as an intriguing iconoclast. Too many people assess all possible consequences before they attempt to right the wrongs they see, but that is not how surgeons work, and Dr. Koop was a surgeon.

His early career as pediatric surgeon restoring, he hoped, wholeness to malformed babies, reverberated in his intervention in the celebrated Baby Doe controversies. Koop can be called a paternalist: he knew what was good for other people and he chose to do it. In 1992 more than a few might disagree with the benevolent parentalism that suffuses these memoirs, and some might search also for a stronger sense of doubt. But doubt rarely leavens Dr. Koop's account. Koop prayed each morning for guidance, but if the Lord ever disagreed with him, we never hear about it. Yet in his story about his decisions as surgeon general, we learn that he can change his attitudes when reason conflicts with faith. When circumstances forced him to rethink his positions, Everett Koop tried to mediate compromise.

Yet, America is a secular society, even if "under God." Dr. Koop fully understands that our country has worked best when religious men and women have tried to strengthen that grand secularism and carefully refrained from forcing their own view of morality on others. There are some matters on which most can agree, and the will of the majority usually should have its way. Still, "God writes straight with crooked lines." This country can well endure the tides of political hegemony moving Left and Right, but we need more fighters like Dr. Koop in public life even if we may not always agree with them. This autobiography will inspire the young who want to help their fellows by becoming physicians. Well-written, captivating even, it will fill them with the vigor they need to want to do as much with their lives as Dr. Koop

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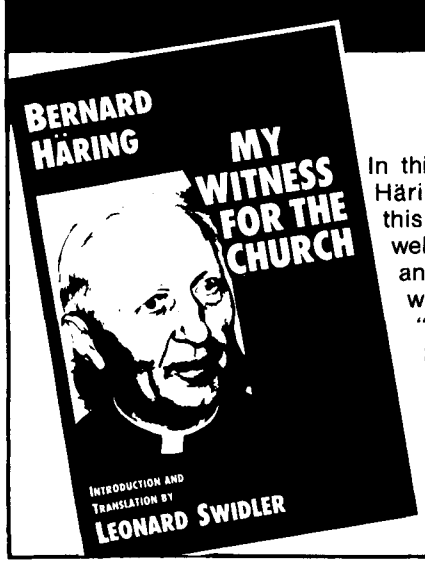

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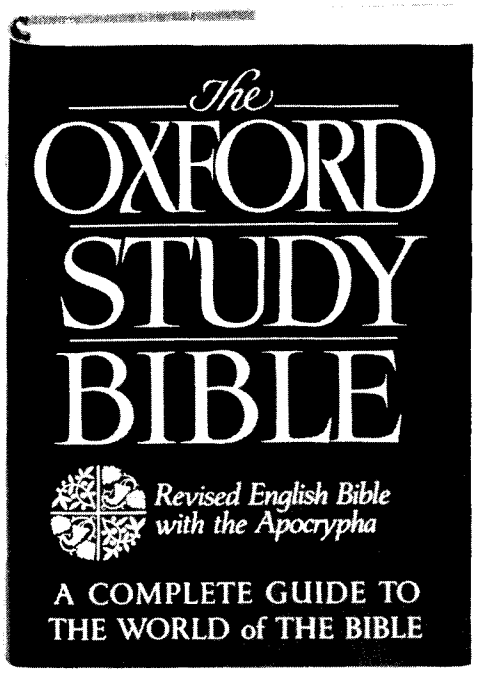

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